Electronic Data Interchange (EDI)

- Supervisor must file claims Electronically with EDI within 2 working day of employee notice

- Filing Claims Electronically
  https://extranet.apps.cpms.osd.mil/Divisions/Benefits%20and%20Worklife/Injury%20and%20Unemployment%20Compensation%20Branch/Online%20Tools%20Overview/DIUCS%20Supervisor%20Link.aspx

- Supervisor should call or email ICPA regarding notification on electronic posting

- Supervisor should forward any Medical Documentation received from employee to

Electronic Data Interchange (EDI)

- It has been DoD policy since July 2003 to utilize EDI when submitting claims
- DOL will be monitoring agency timeliness for claim submission as a result of SHARE
- Defense Safety Oversight Council (DSOC) will be monitoring DoD agency timeliness and use of EDI for claim

Electronic Data Interchange (EDI)

- Claims filed utilizing EDI are electronically transmitted to OWCP from the agency
- Any delay due to internal routing of paper claims and mailing forms to OWCP are eliminated

CLAIM PROCESS

- Employee reports the injury to his/her supervisor
- Process is started by accessing the EDI website
- Supervisor and employee complete the electronic form, which is transmitted to the ICPA. Supervisors do not need any special access to file the claim electronically, only a computer with internet access

CLAIM PROCESS

- ICPA receives an email notification of the supervisor’s claim submission
- ICPA will receive, via email, a copy of the OSHA 301 to forward to the appropriate Safety Office if that Safety Office does not have an established alias

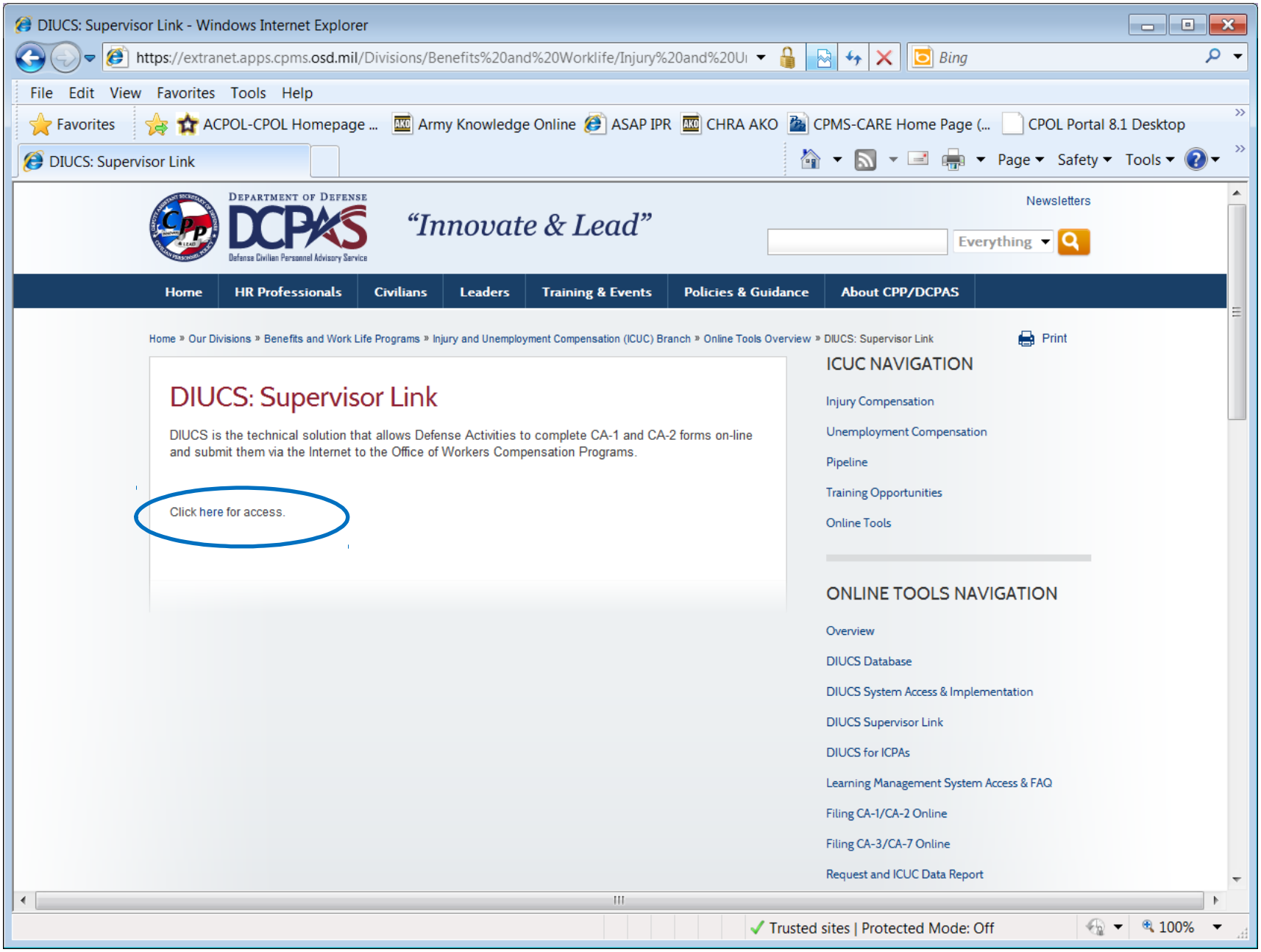
CLAIM PROCESS

- ICPA “authenticates” the form (i.e. verifies employment status, enters appropriate codes, corrects any errors); form is then transmitted to DOL
- If there are no problems with the claim, the ICPA will receive an email with the case number within 2-3 business days
- If there are problems with the claim then the ICPA will receive an email notification of the claim rejection and the reason for the rejection

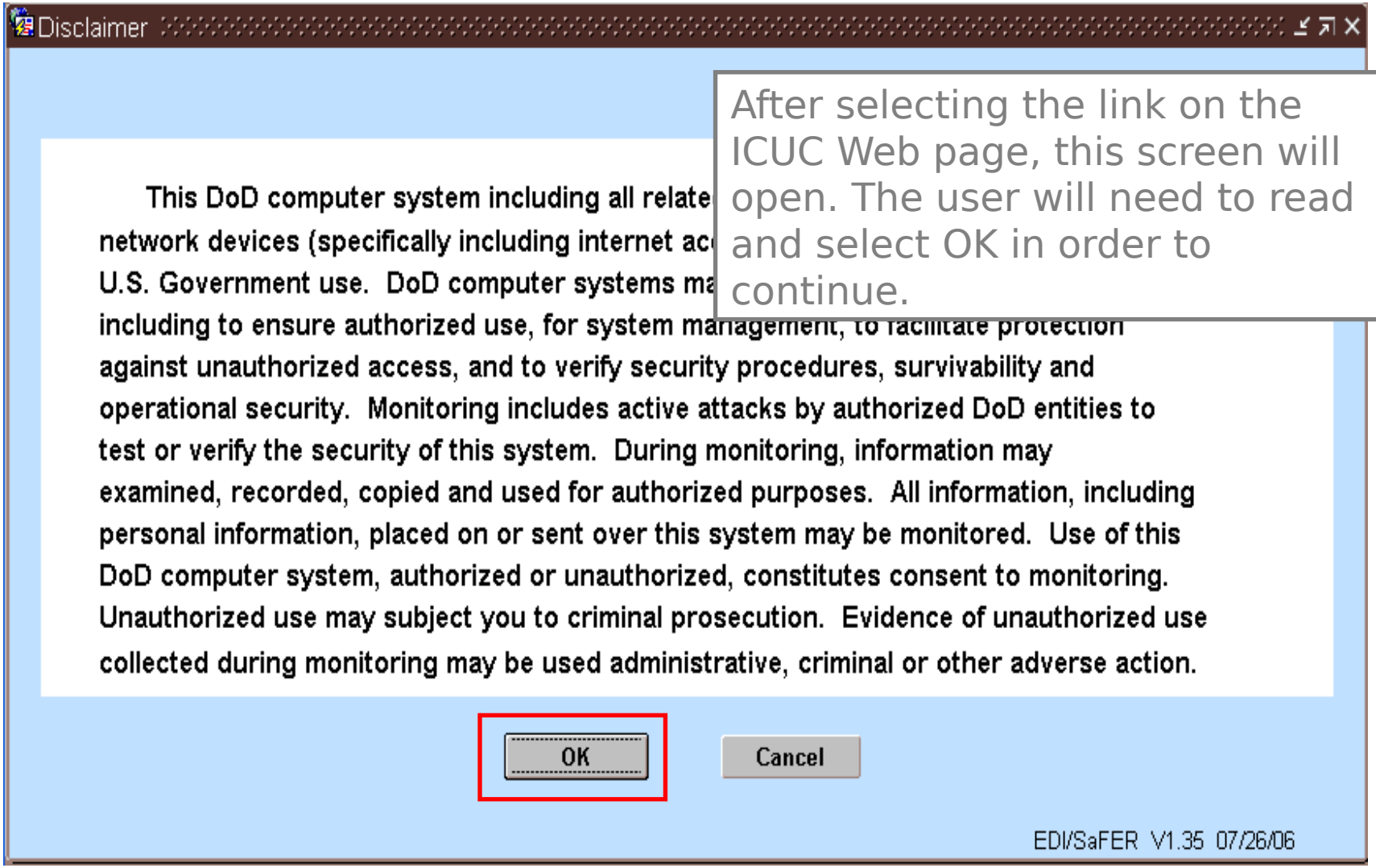
CLAIM PROCESS

- If there are problems with the claim then the ICPA will receive an email notification of the claim rejection and the reason for the rejection

- The EDI forms are patterned directly on the hard copy forms CA-1 and CA-2. Therefore, the basic instructions for completing the forms are the same as with paper

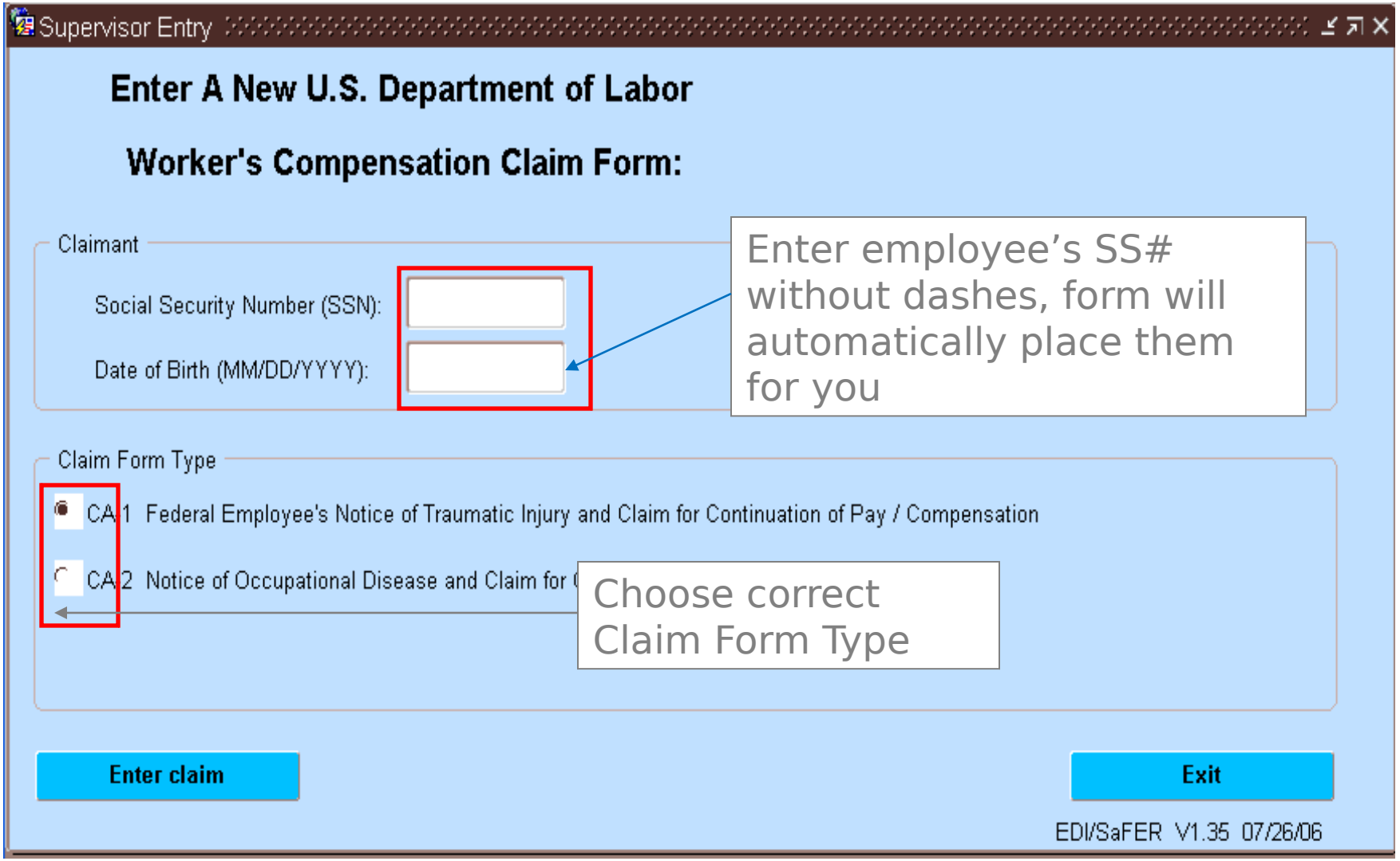

DIUCS: Supervisor Link - Windows Internet Explorer
https://extranet.apps.cpms.osd.mil/Divisions/Benefits%20and%20Worklife/Injury%20and%20U
Bing
File Edit View Favorites Tools Help
Favorites
ACPOL-CPOL Homepage ...
Army Knowledge Online
ASAP IPR
CHRA AKO
CPMS-CARE Home Page (...
CPOL Portal 8.1 Desktop
DIUCS: Supervisor Link
Page
Safety
Tools
Department of Defense
DCPAS
Defense Civilian Personnel Advisory Service
"Innovate & Lead"
Newsletters
Everything
Home
HR Professionals
Civilians
Leaders
Training & Events
Policies & Guidance
About CPP/DCPAS
Home » Our Divisions » Benefits and Work Life Programs » Injury and Unemployment Compensation (ICUC) Branch » Online Tools Overview » DIUCS: Supervisor Link
Print
DIUCS: Supervisor Link
DIUCS is the technical solution that allows Defense Activities to complete CA-1 and CA-2 forms on-line and submit them via the Internet to the Office of Workers Compensation Programs.
Click here for access.
ICUC NAVIGATION
Injury Compensation
Unemployment Compensation
Pipeline
Training Opportunities
Online Tools
ONLINE TOOLS NAVIGATION
Overview
DIUCS Database
DIUCS System Access & Implementation
DIUCS Supervisor Link
DIUCS for ICPAs
Learning Management System Access & FAQ
Filing CA-1/CA-2 Online
Filing CA-3/CA-7 Online
Request and ICUC Data Report
Trusted sites | Protected Mode: Off
100%

EDI FORM

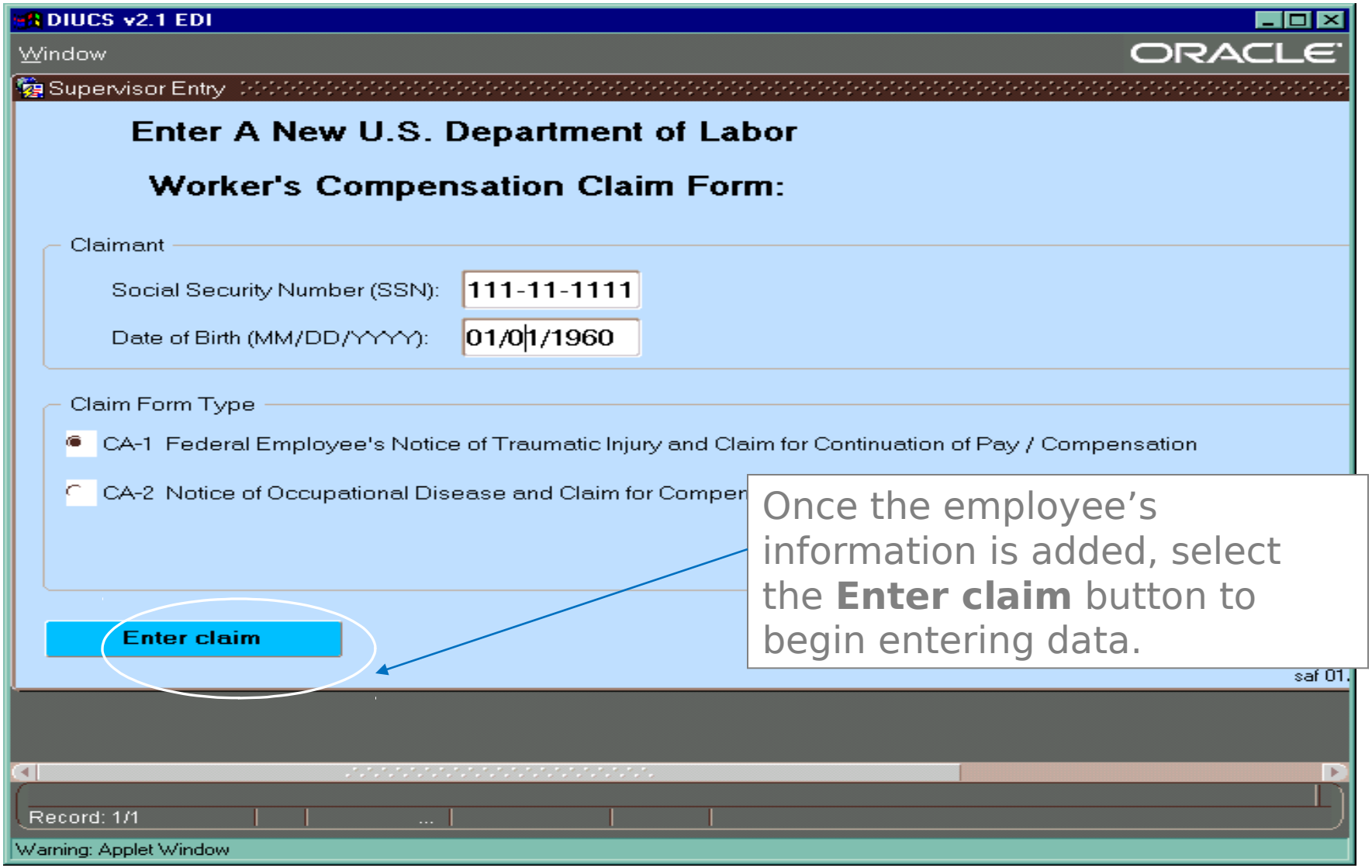


After selecting the link on the ICUC Web page, this screen will open. The user will need to read and select OK in order to continue.

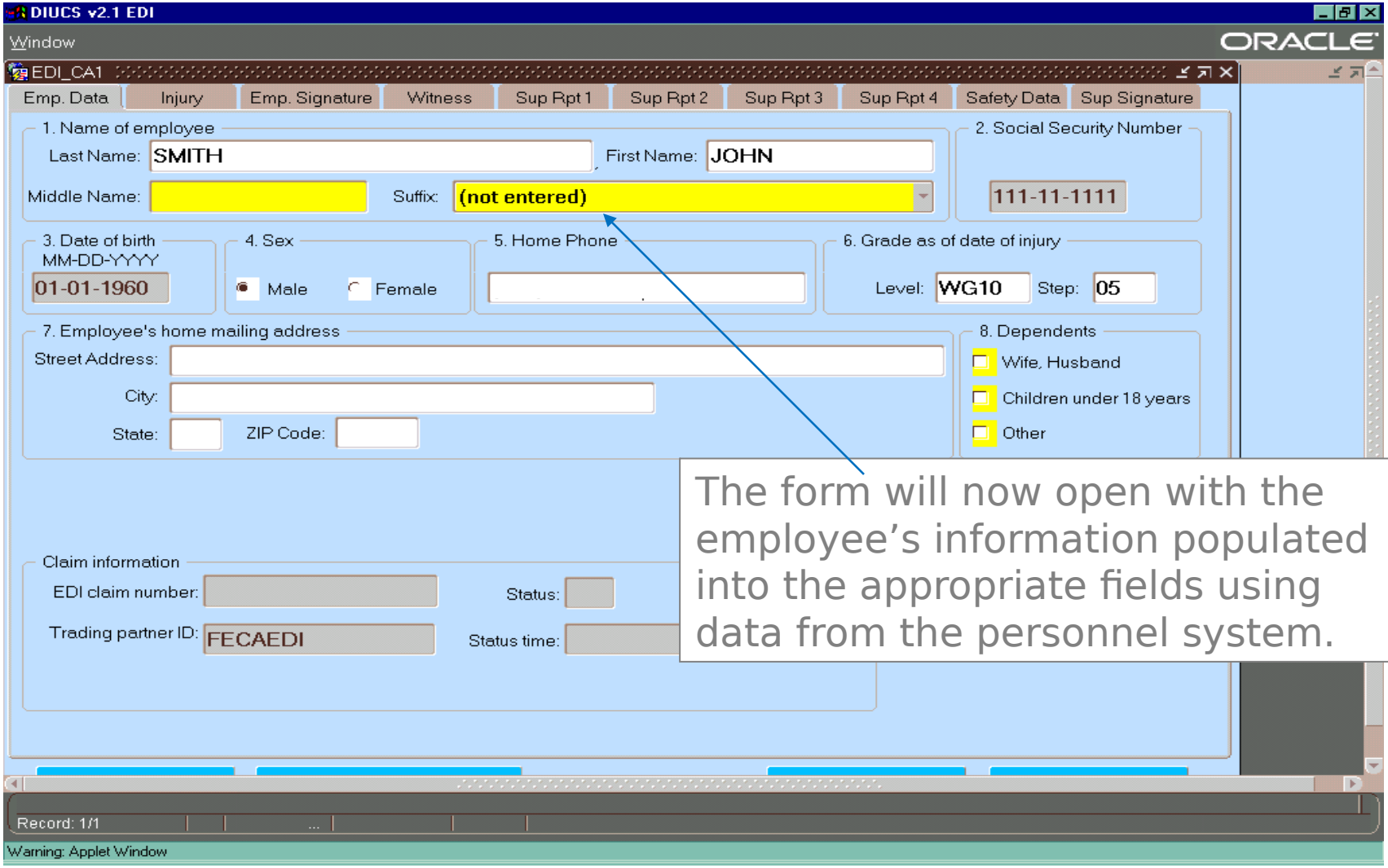
EDI FORM


Supervisor Entry
Enter A New U.S. Department of Labor
Worker's Compensation Claim Form:
Claimant
Social Security Number (SSN):
Date of Birth (MM/DD/YYYY):
Enter employee's SS# without dashes, form will automatically place them for you
Claim Form Type
CA 1 Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay / Compensation
CA 2 Notice of Occupational Disease and Claim for
Choose correct Claim Form Type
Enter claim
Exit
EDI/SaFER V1.35 07/26/06

EDI FORM

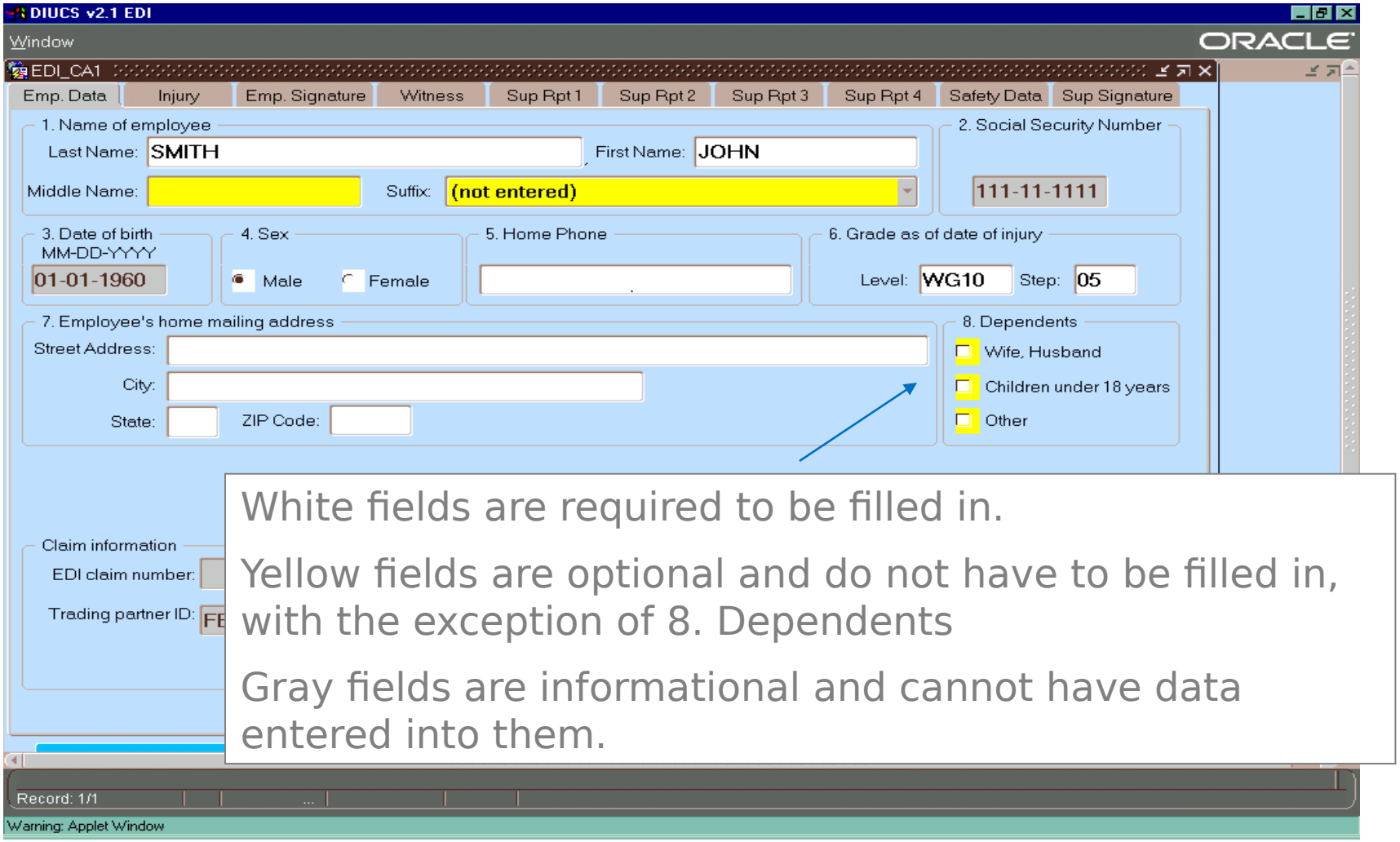

DIUCS v2.1 EDI
Window
ORACLE
Supervisor Entry
Enter A New U.S. Department of Labor
Worker's Compensation Claim Form:
Claimant
Social Security Number (SSN):
111-11-1111
Date of Birth (MM/DD/YYYY):
01/01/1960
Claim Form Type
CA-1 Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay / Compensation
CA-2 Notice of Occupational Disease and Claim for Compen
Enter claim
Once the employee's information is added, select the Enter claim button to begin entering data.
Record: 1/1
Warning: Applet Window

EDI FORM



The form will now open with the employee's information populated into the appropriate fields using data from the personnel system.

EDI FORM

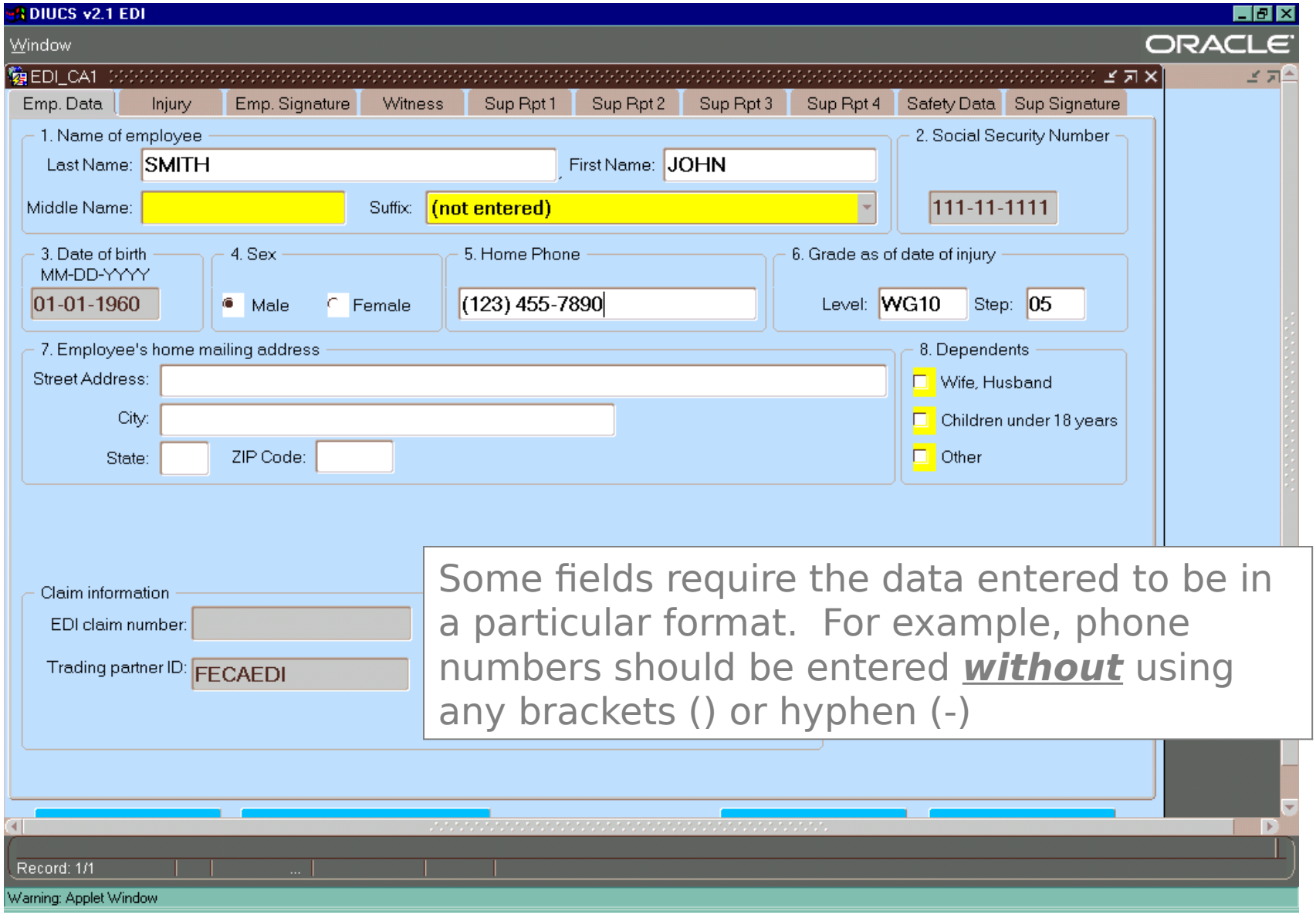


White fields are required to be filled in.

Yellow fields are optional and do not have to be filled in, with the exception of 8. Dependents

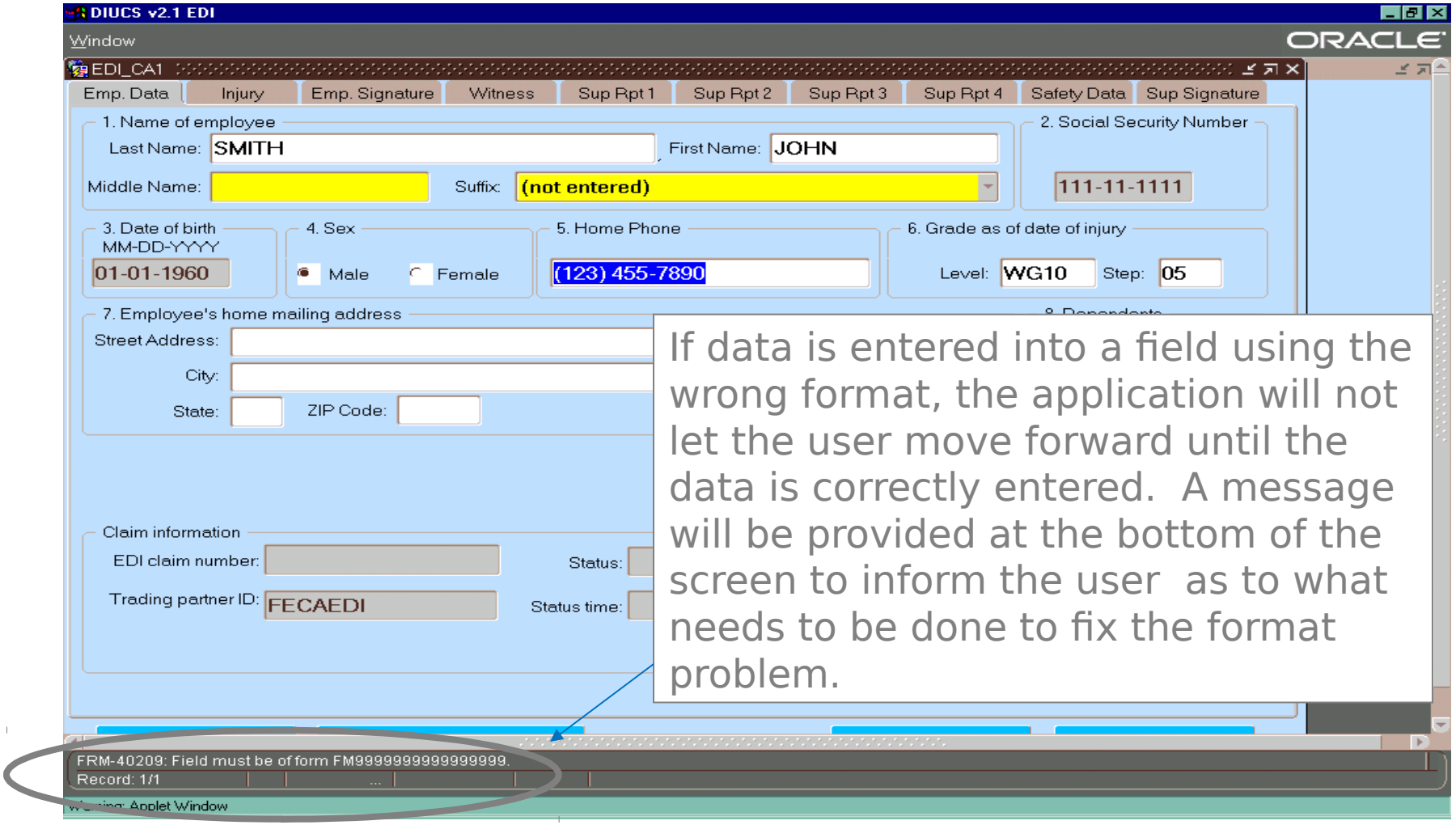
Gray fields are informational and cannot have data entered into them.

EDI FORM



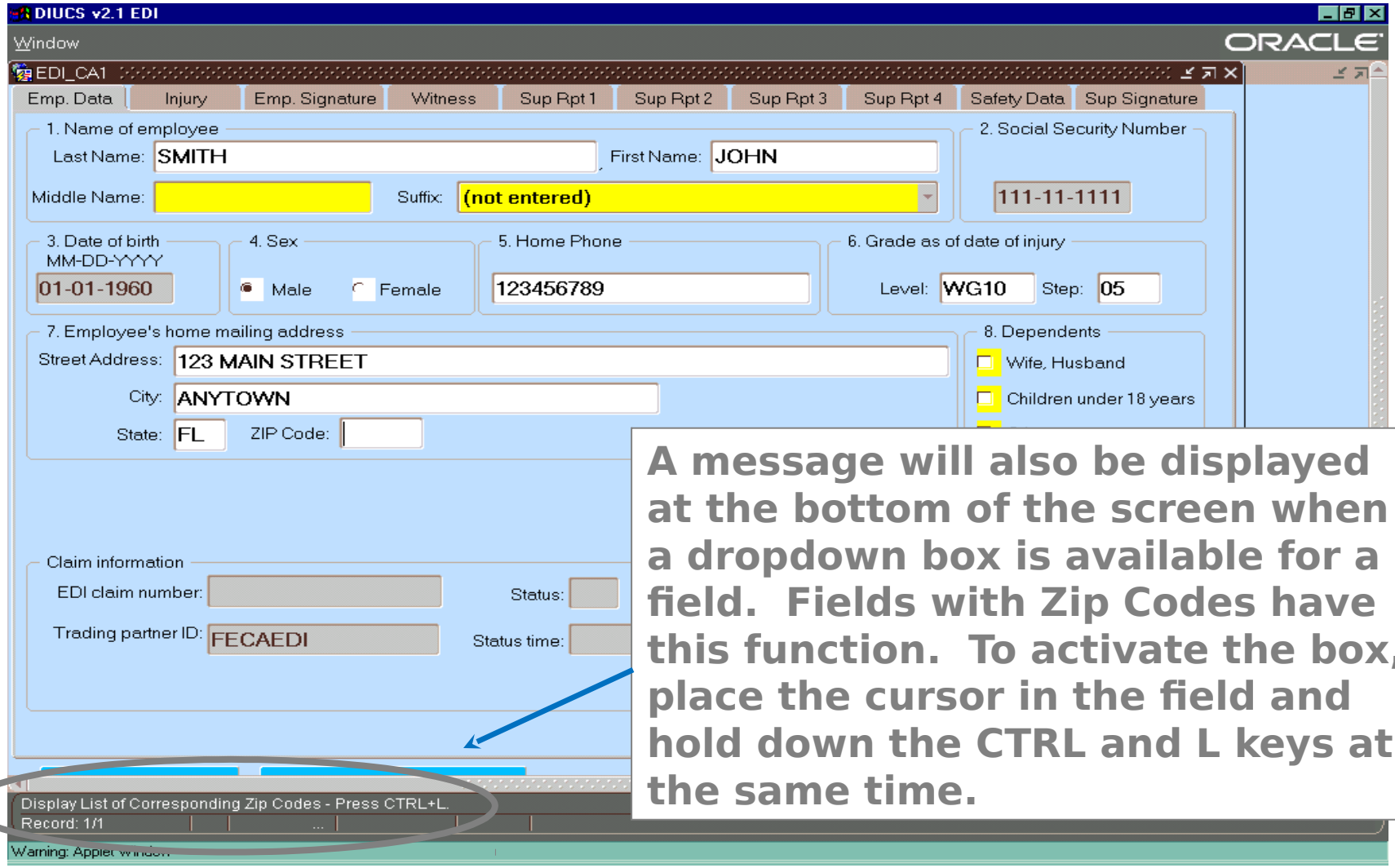
Some fields require the data entered to be in a particular format. For example, phone numbers should be entered ***without*** using any brackets () or hyphen (-)

EDI FORM



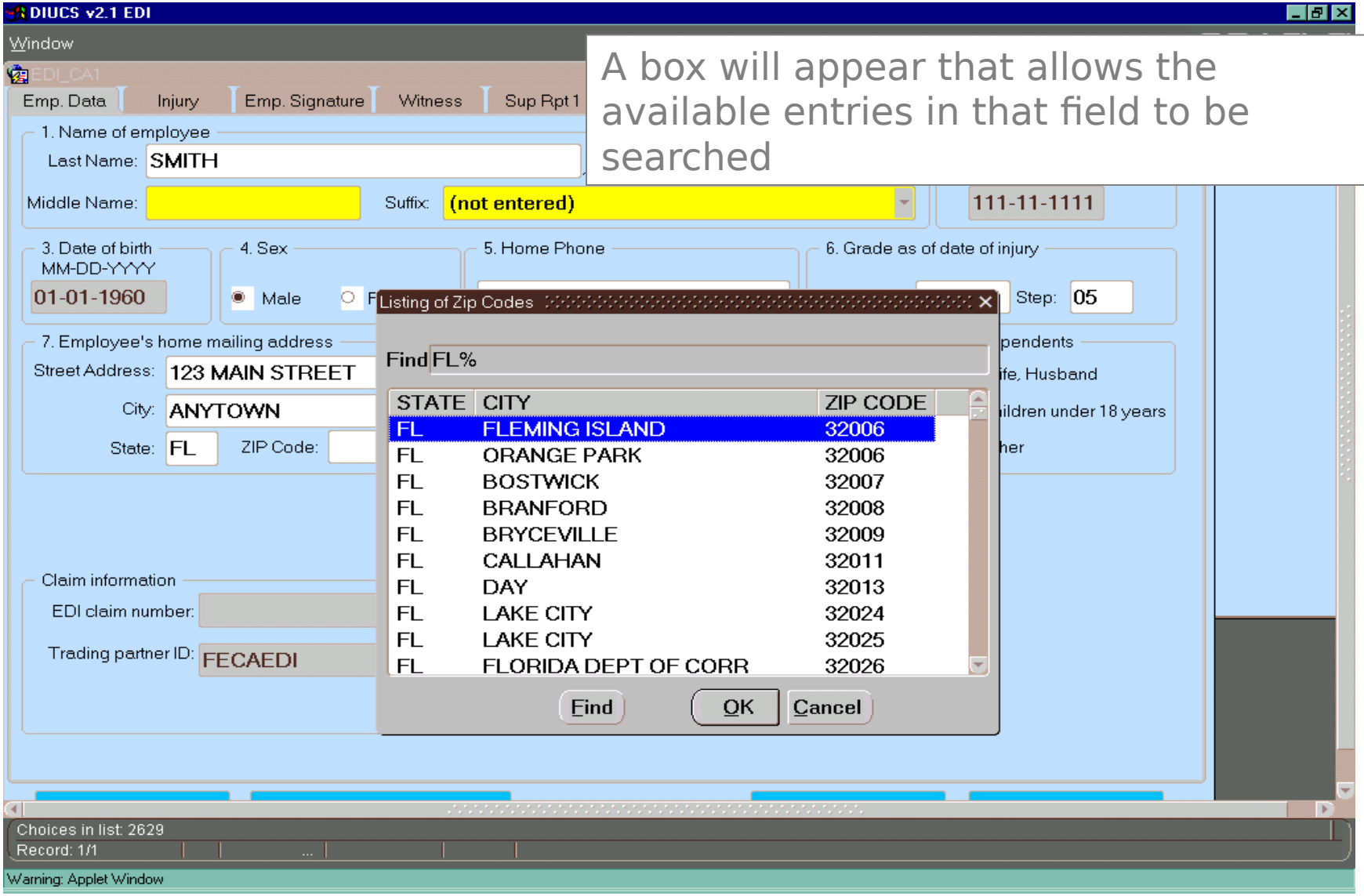
If data is entered into a field using the wrong format, the application will not let the user move forward until the data is correctly entered. A message will be provided at the bottom of the screen to inform the user as to what needs to be done to fix the format problem.

EDI FORM



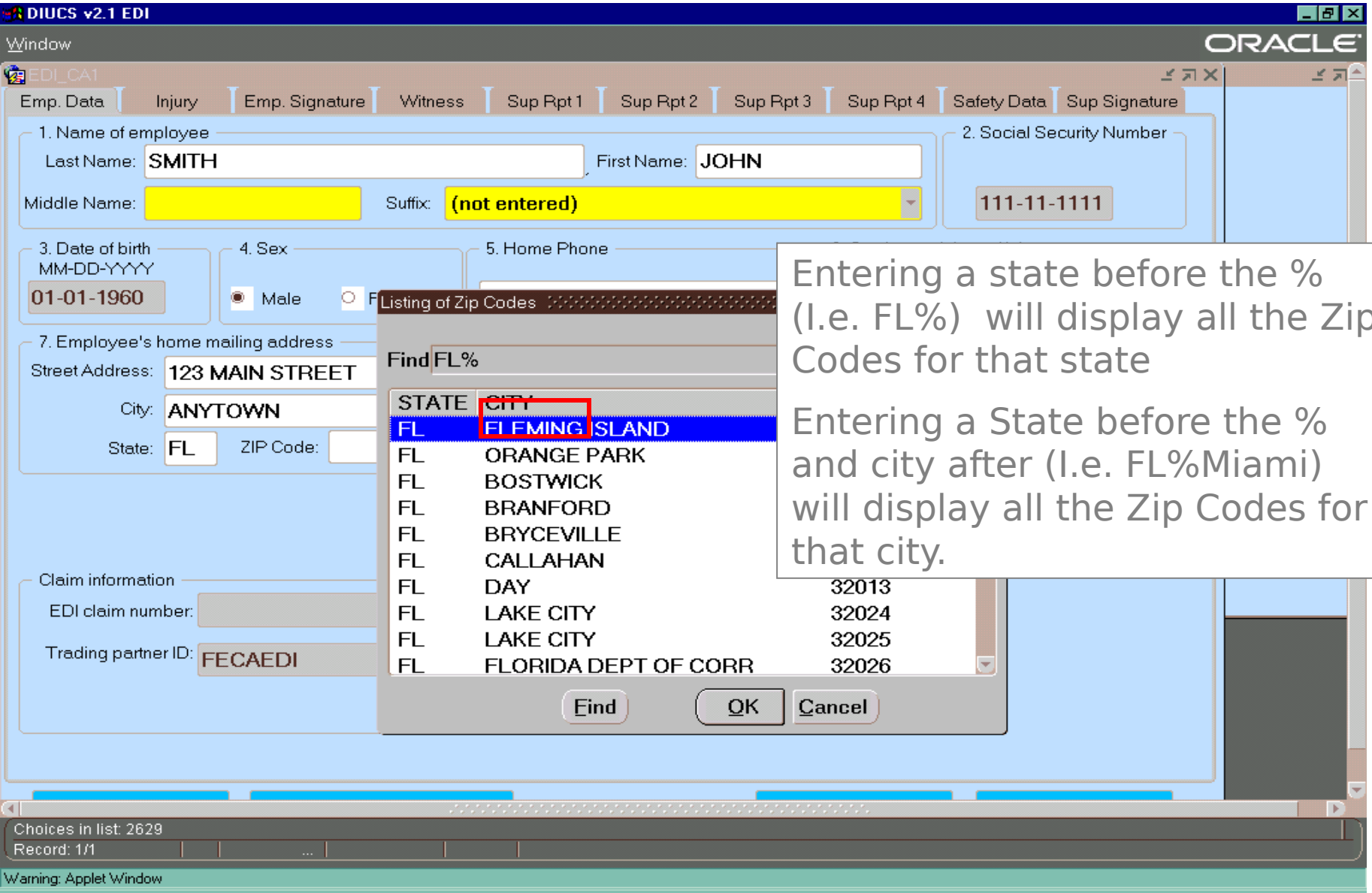
A message will also be displayed at the bottom of the screen when a dropdown box is available for a field. Fields with Zip Codes have this function. To activate the box, place the cursor in the field and hold down the CTRL and L keys at the same time.

EDI FORM



A box will appear that allows the available entries in that field to be searched

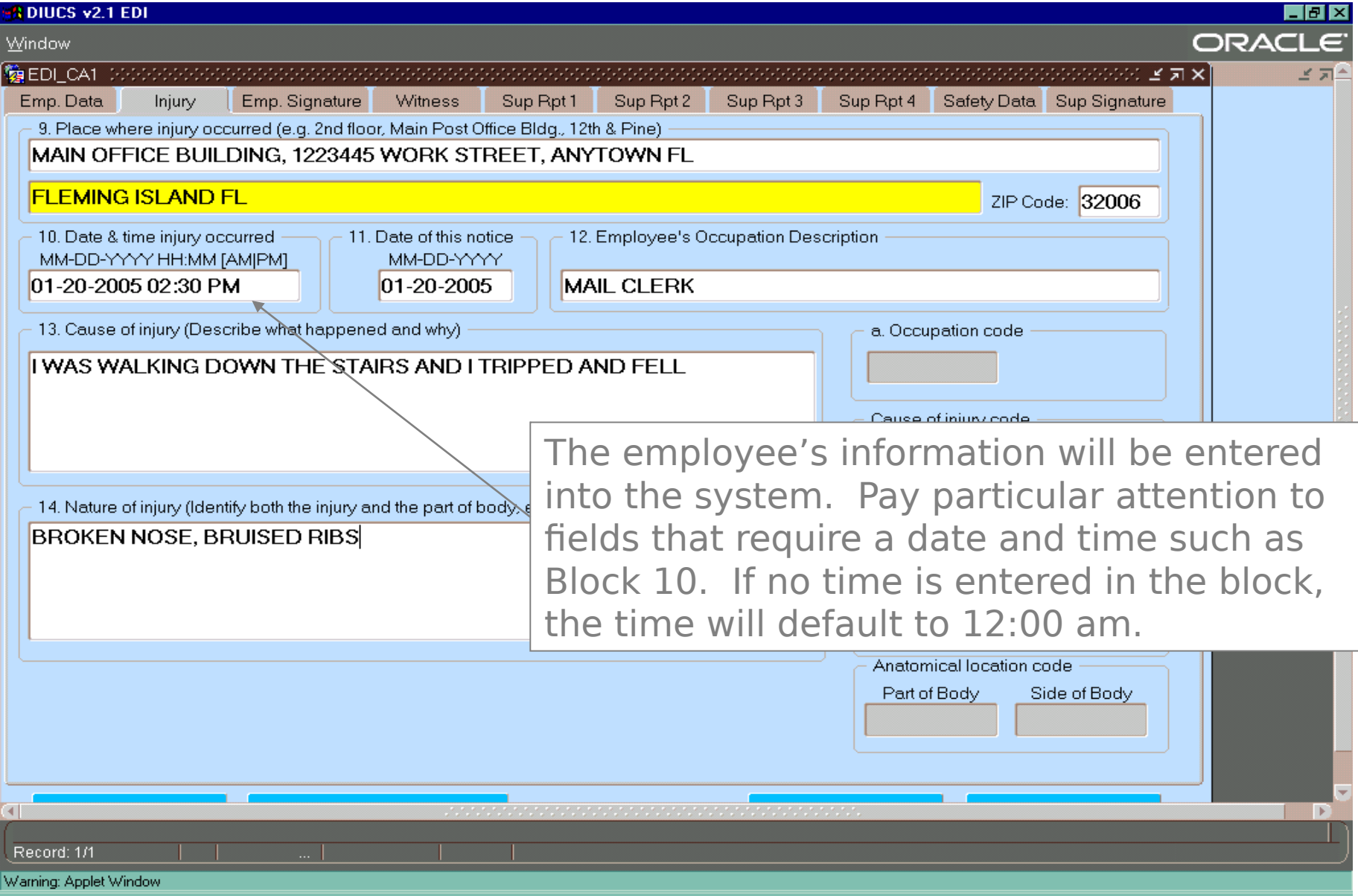
EDI FORM



Entering a state before the % (I.e. FL%) will display all the Zip Codes for that state

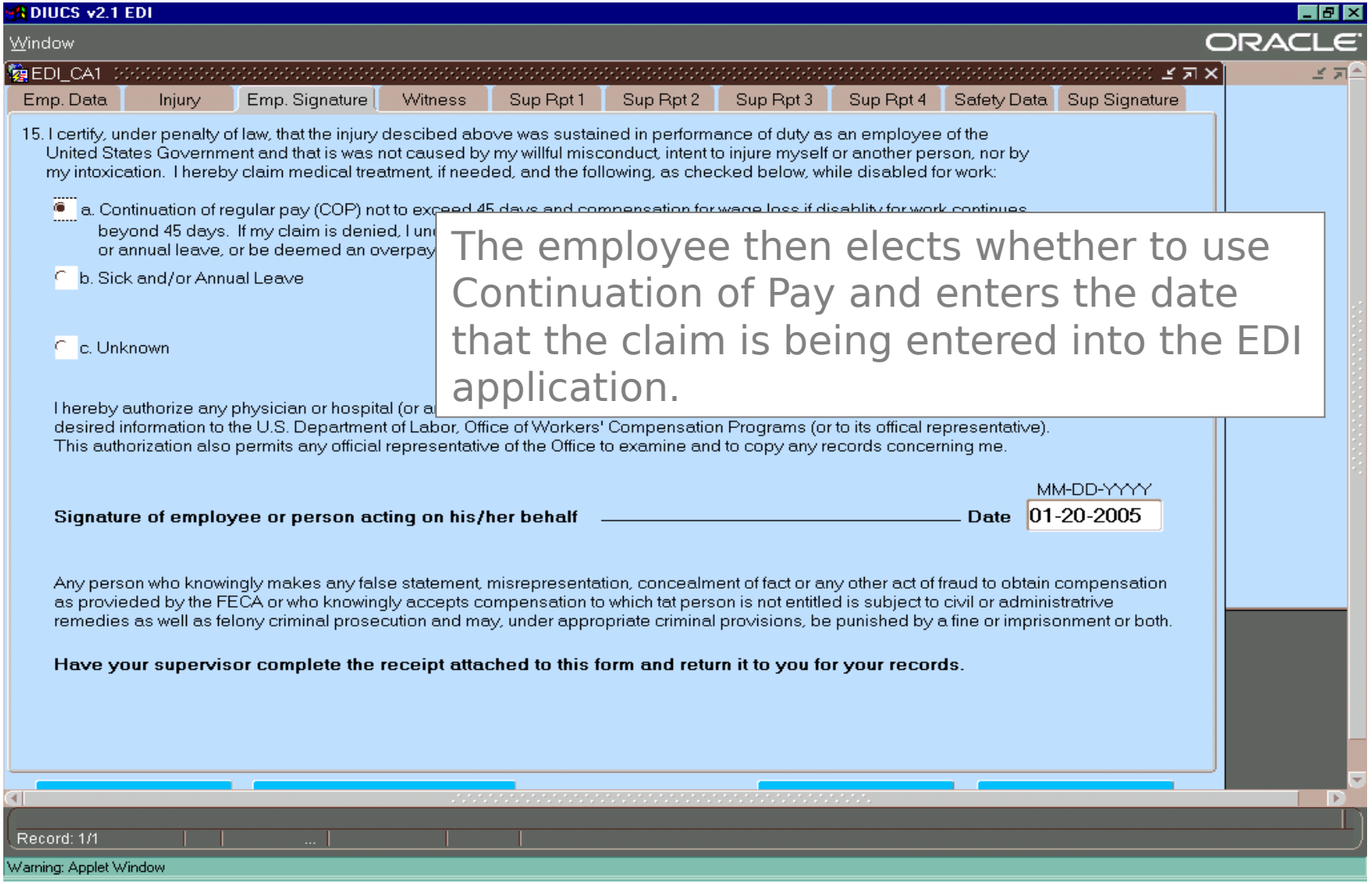
Entering a State before the % and city after (I.e. FL%Miami) will display all the Zip Codes for that city.

EDI FORM



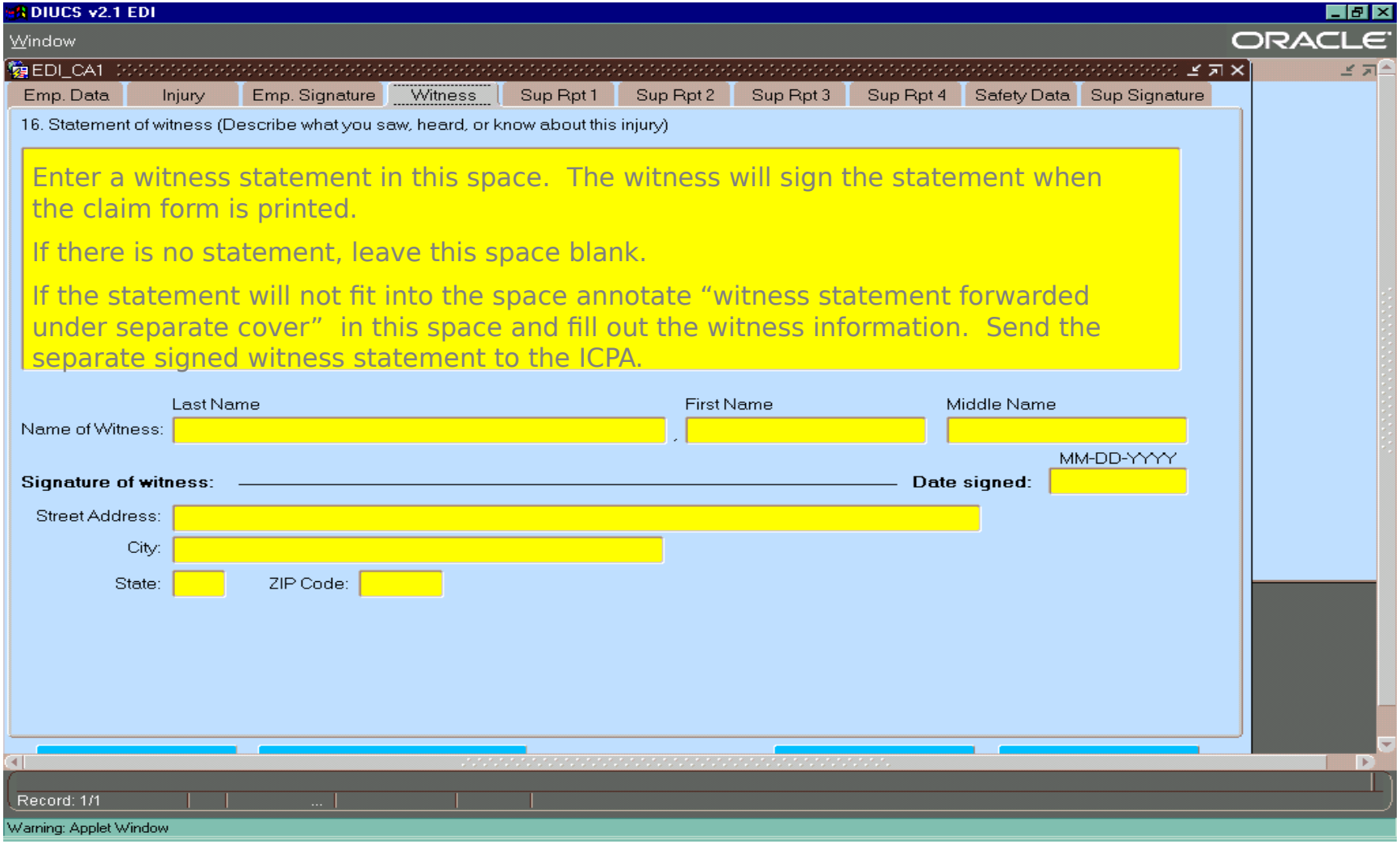
The employee's information will be entered into the system. Pay particular attention to fields that require a date and time such as Block 10. If no time is entered in the block, the time will default to 12:00 am.

EDI FORM

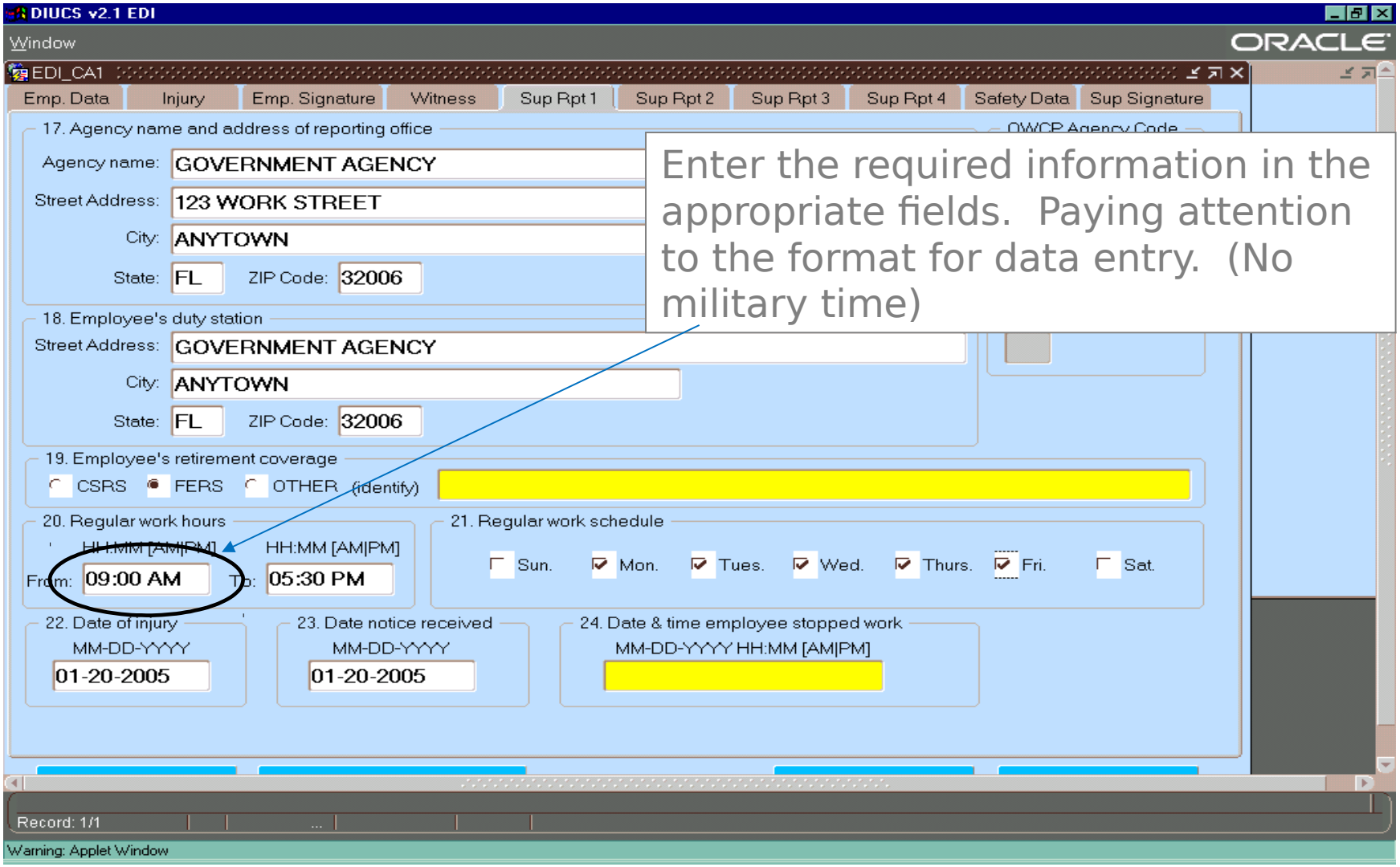


The employee then elects whether to use Continuation of Pay and enters the date that the claim is being entered into the EDI application.

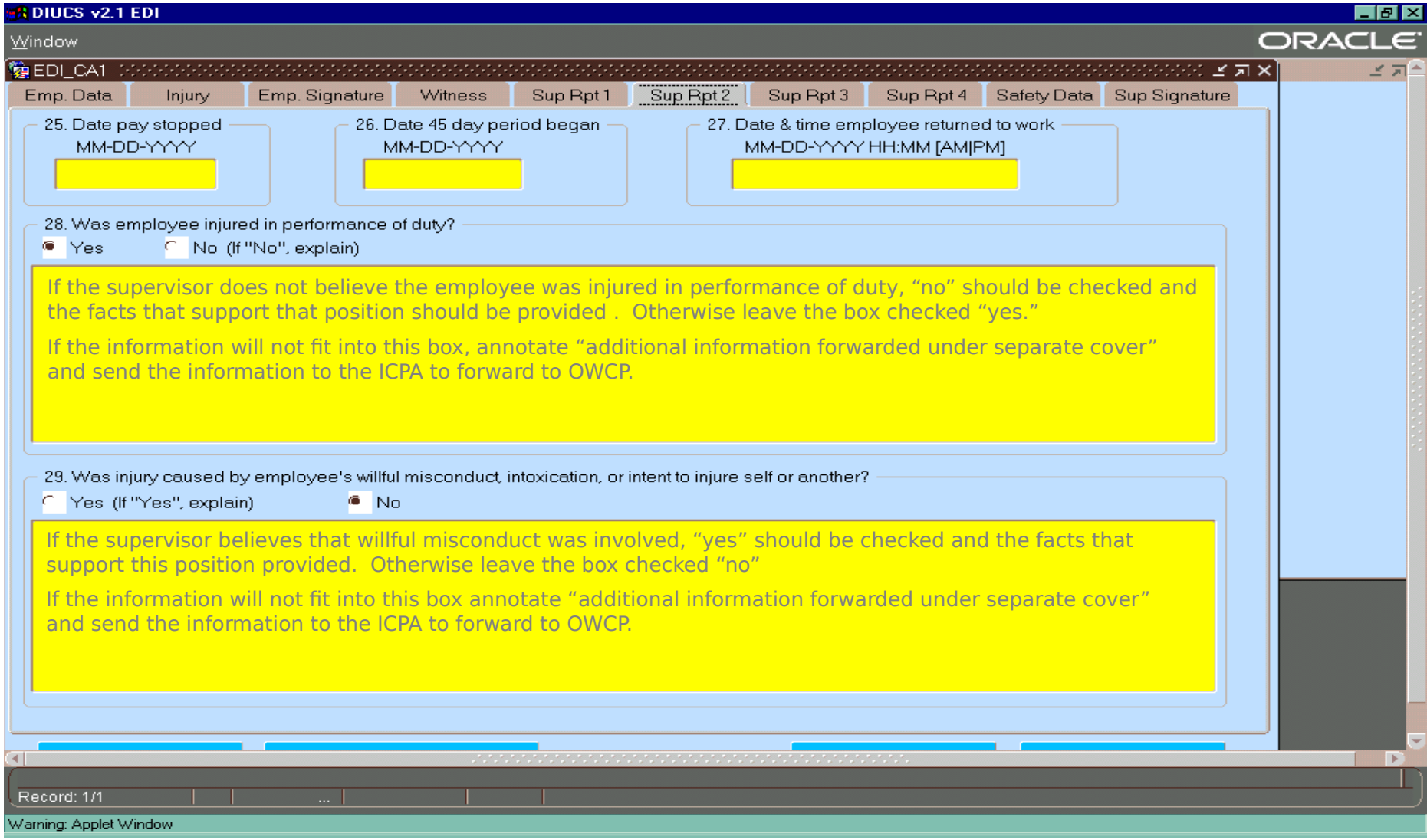
EDI FORM


DIUCS v2.1 EDI
Window
ORACLE
EDI_CA1
Emp. Data
Injury
Emp. Signature
Witness
Sup Rpt 1
Sup Rpt 2
Sup Rpt 3
Sup Rpt 4
Safety Data
Sup Signature
16. Statement of witness (Describe what you saw, heard, or know about this injury)
Enter a witness statement in this space. The witness will sign the statement when the claim form is printed.
If there is no statement, leave this space blank.
If the statement will not fit into the space annotate "witness statement forwarded under separate cover" in this space and fill out the witness information. Send the separate signed witness statement to the ICPA.
Last Name
First Name
Middle Name
Name of Witness:
MM-DD-YYYY
Signature of witness:
Date signed:
Street Address:
City:
State:
ZIP Code:
Record: 1/1
Warning: Applet Window

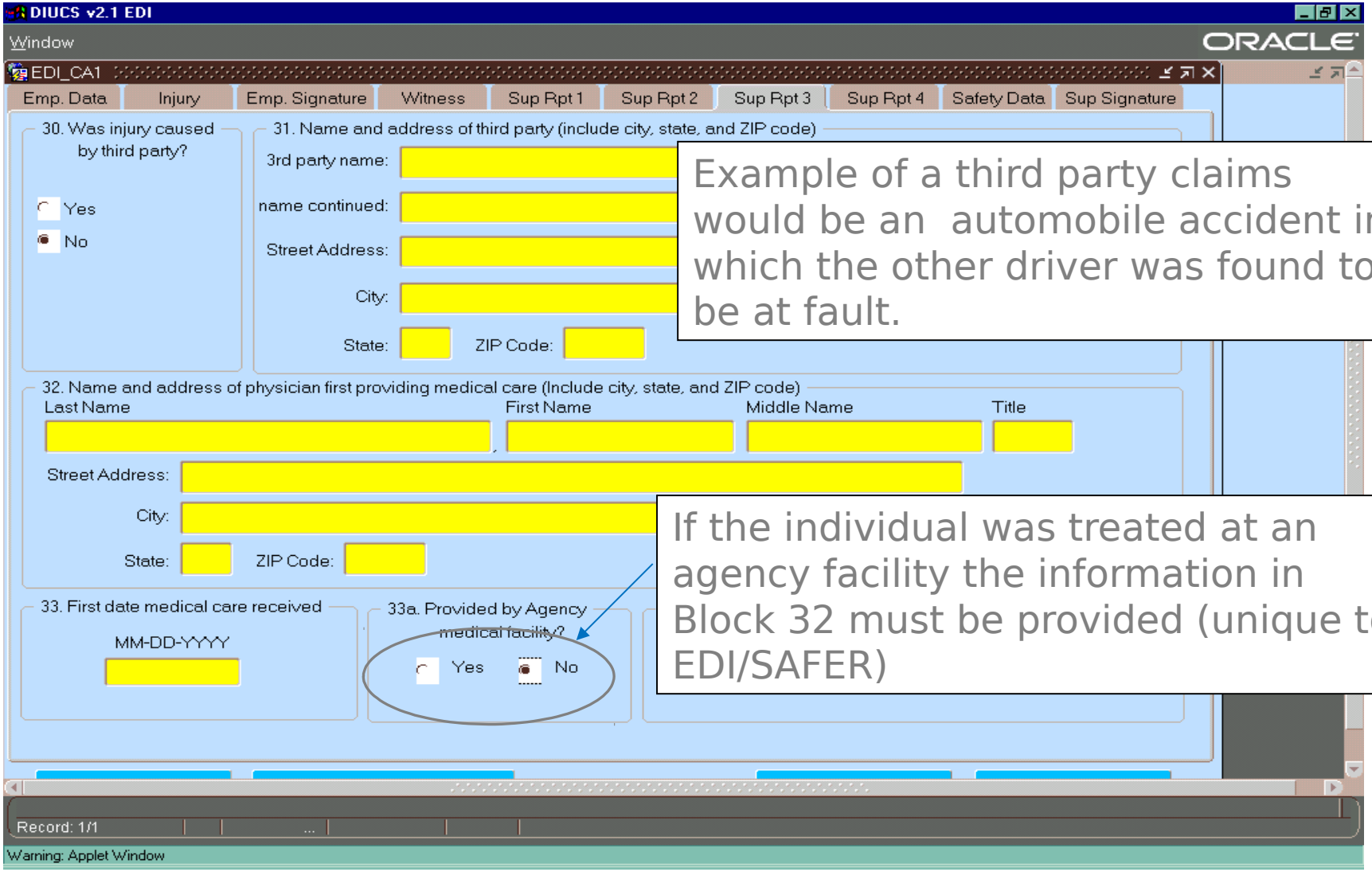
EDI FORM


DIUCS v2.1 EDI
Window
ORACLE
EDI_CA1
Emp. Data
Injury
Emp. Signature
Witness
Sup Rpt 1
Sup Rpt 2
Sup Rpt 3
Sup Rpt 4
Safety Data
Sup Signature
17. Agency name and address of reporting office
OWCP Agency Code
Agency name: GOVERNMENT AGENCY
Street Address: 123 WORK STREET
City: ANYTOWN
State: FL
ZIP Code: 32006
18. Employee's duty station
Street Address: GOVERNMENT AGENCY
City: ANYTOWN
State: FL
ZIP Code: 32006
19. Employee's retirement coverage
CSRS
FERS
OTHER (identify)
20. Regular work hours
HH:MM [AM|PM]
From: 09:00 AM
To:
HH:MM [AM|PM]
05:30 PM
21. Regular work schedule
Sun.
Mon.
Tues.
Wed.
Thurs.
Fri.
Sat.
22. Date of injury
MM-DD-YYYY
01-20-2005
23. Date notice received
MM-DD-YYYY
01-20-2005
24. Date & time employee stopped work
MM-DD-YYYY HH:MM [AM|PM]
Record: 1/1
Warning: Applet Window
Enter the required information in the appropriate fields. Paying attention to the format for data entry. (No military time)

EDI FORM


DIUCS v2.1 EDI
Window
ORACLE
EDI_CA1
Emp. Data
Injury
Emp. Signature
Witness
Sup Rpt 1
Sup Rpt 2
Sup Rpt 3
Sup Rpt 4
Safety Data
Sup Signature
25. Date pay stopped
MM-DD-YYYY
26. Date 45 day period began
MM-DD-YYYY
27. Date & time employee returned to work
MM-DD-YYYY HH:MM [AM|PM]
28. Was employee injured in performance of duty?
Yes
No (If "No", explain)
If the supervisor does not believe the employee was injured in performance of duty, “no” should be checked and the facts that support that position should be provided . Otherwise leave the box checked “yes.”
If the information will not fit into this box, annotate “additional information forwarded under separate cover” and send the information to the ICPA to forward to OWCP.
29. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another?
Yes (If "Yes", explain)
No
If the supervisor believes that willful misconduct was involved, “yes” should be checked and the facts that support this position provided. Otherwise leave the box checked “no”
If the information will not fit into this box annotate “additional information forwarded under separate cover” and send the information to the ICPA to forward to OWCP.
Record: 1/1
Warning: Applet Window

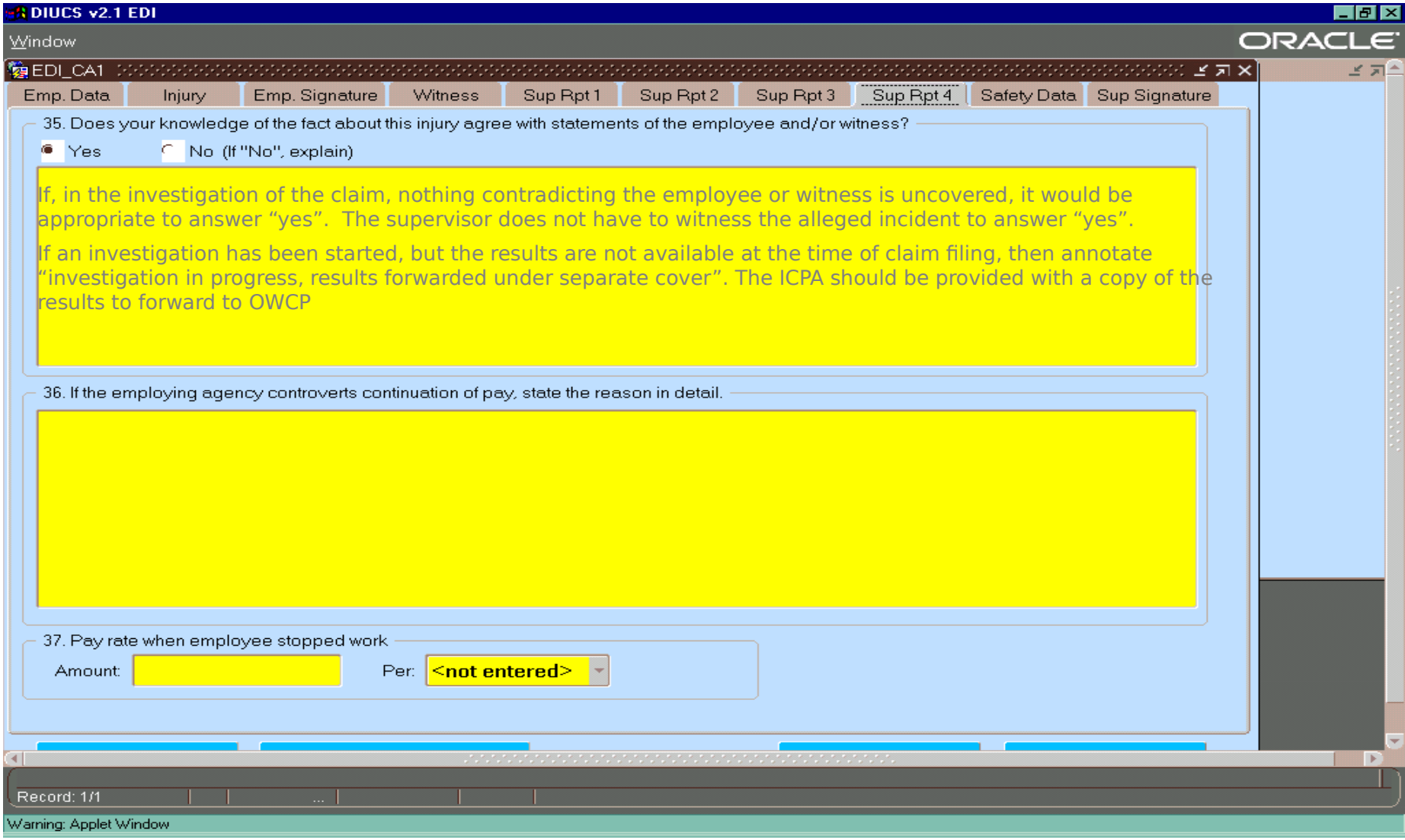
EDI FORM



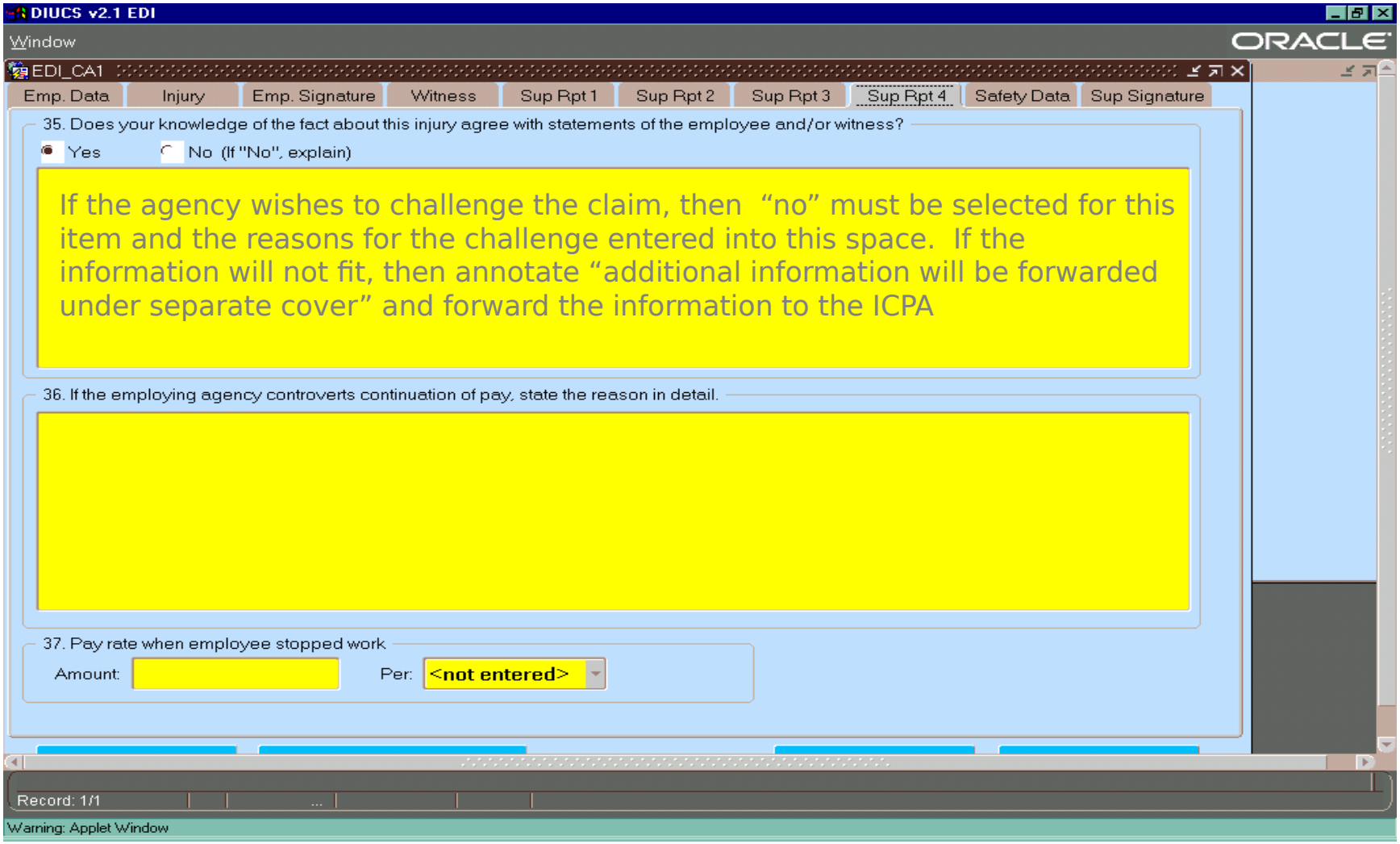
Example of a third party claims would be an automobile accident in which the other driver was found to be at fault.

If the individual was treated at an agency facility the information in Block 32 must be provided (unique to EDI/SAFER)

EDI FORM


DIUCS v2.1 EDI
Window
ORACLE
EDI_CA1
Emp. Data
Injury
Emp. Signature
Witness
Sup Rpt 1
Sup Rpt 2
Sup Rpt 3
Sup Rpt 4
Safety Data
Sup Signature
35. Does your knowledge of the fact about this injury agree with statements of the employee and/or witness?
Yes
No (If "No", explain)
If, in the investigation of the claim, nothing contradicting the employee or witness is uncovered, it would be appropriate to answer “yes”. The supervisor does not have to witness the alleged incident to answer “yes”.
If an investigation has been started, but the results are not available at the time of claim filing, then annotate “investigation in progress, results forwarded under separate cover”. The ICPA should be provided with a copy of the results to forward to OWCP
36. If the employing agency controverts continuation of pay, state the reason in detail.
37. Pay rate when employee stopped work
Amount:
Per:
<not entered>
Record: 1/1
Warning: Applet Window

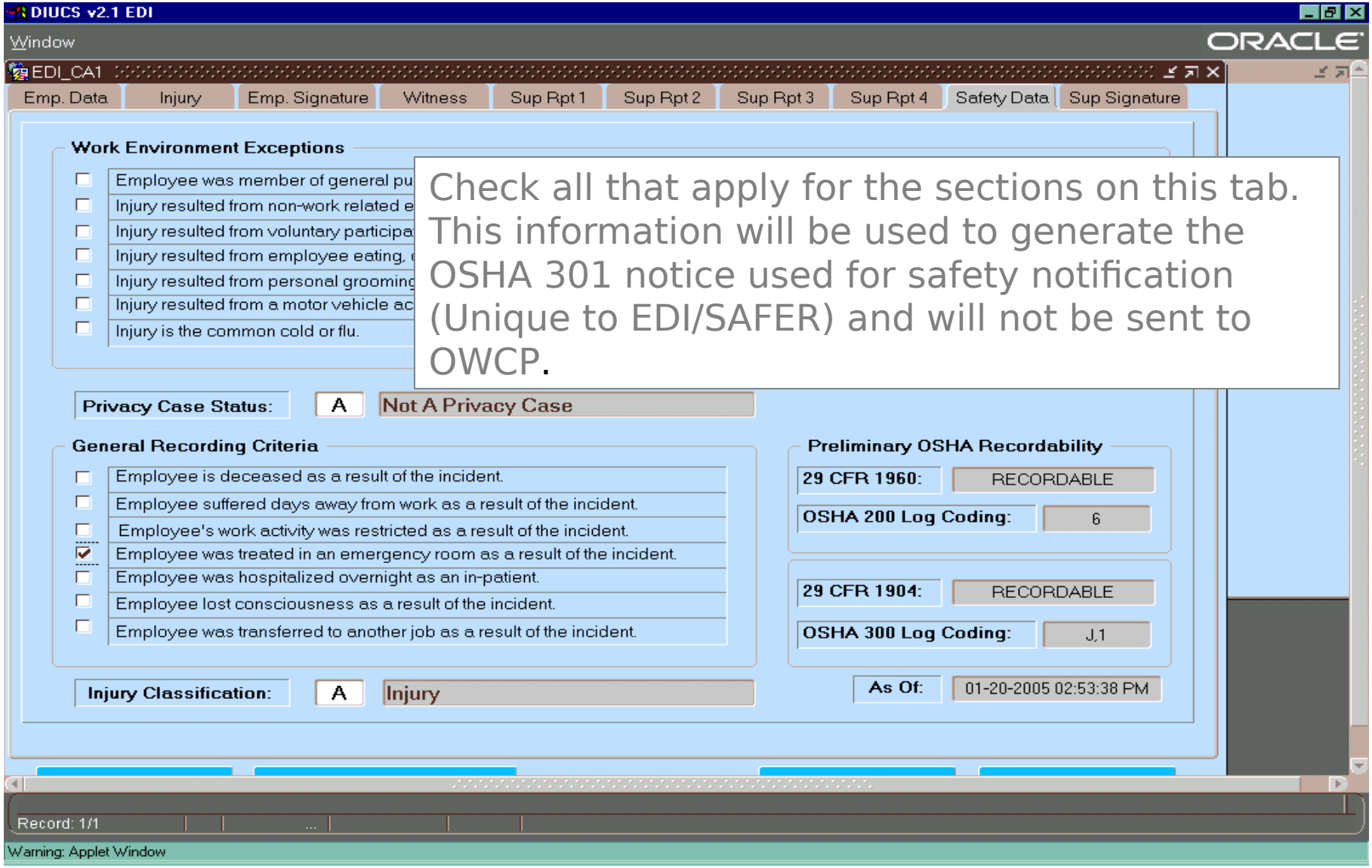
EDI FORM


DIUCS v2.1 EDI
Window
ORACLE
EDI_CA1
Emp. Data
Injury
Emp. Signature
Witness
Sup Rpt 1
Sup Rpt 2
Sup Rpt 3
Sup Rpt 4
Safety Data
Sup Signature
35. Does your knowledge of the fact about this injury agree with statements of the employee and/or witness?
Yes
No (If "No", explain)
If the agency wishes to challenge the claim, then "no" must be selected for this item and the reasons for the challenge entered into this space. If the information will not fit, then annotate "additional information will be forwarded under separate cover" and forward the information to the ICPA
36. If the employing agency controverts continuation of pay, state the reason in detail.
37. Pay rate when employee stopped work
Amount:
Per:
<not entered>
Record: 1/1
Warning: Applet Window

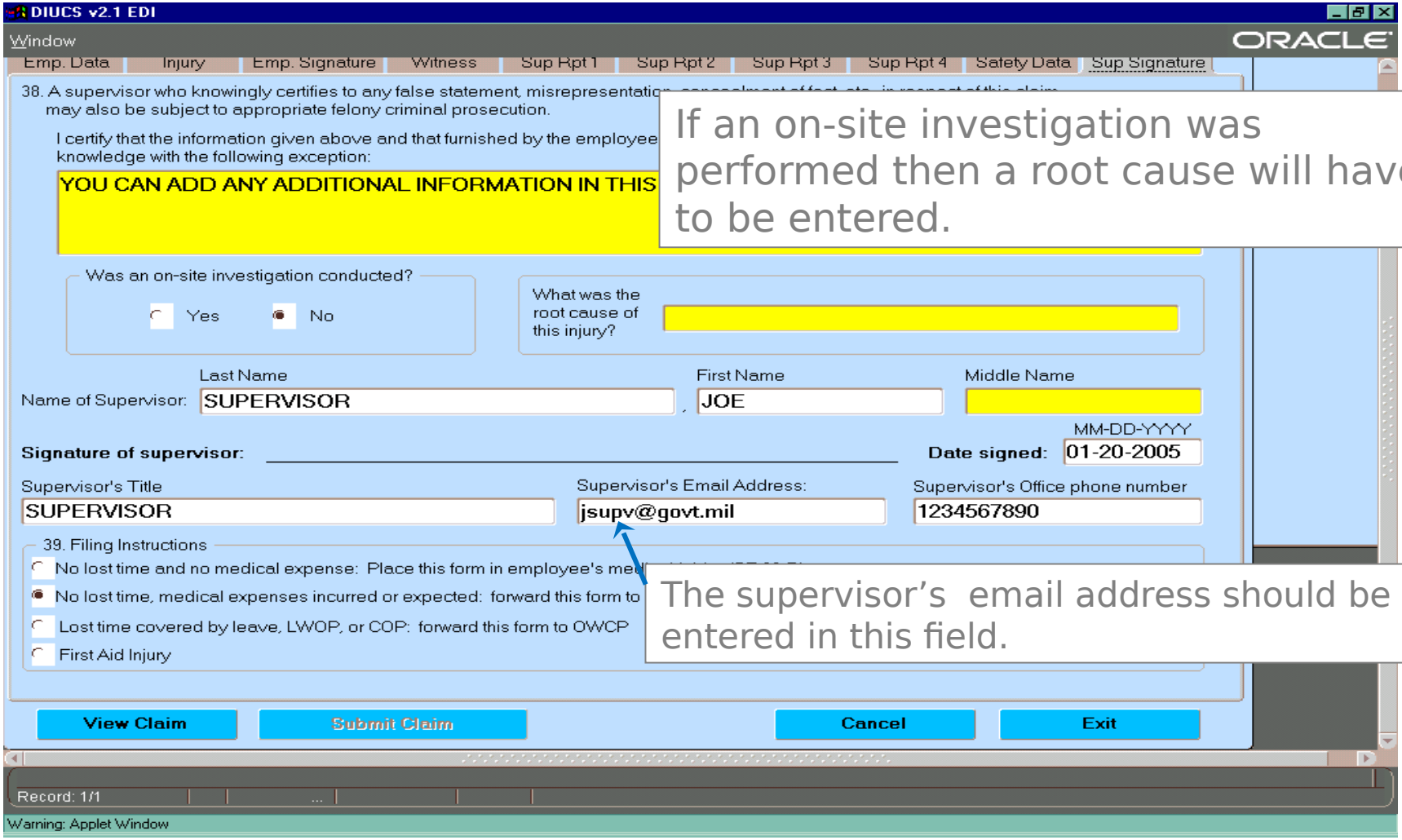
EDI FORM


DIUCS v2.1 EDI
Window
ORACLE
EDI_CA1
Emp. Data
Injury
Emp. Signature
Witness
Sup Rpt 1
Sup Rpt 2
Sup Rpt 3
Sup Rpt 4
Safety Data
Sup Signature
35. Does your knowledge of the fact about this injury agree with statements of the employee and/or witness?
Yes
No (If "No", explain)
36. If the employing agency controverts continuation of pay, state the reason in detail.
Enter the reason for the controversion of COP in this space.
37. Pay rate when employee stopped work
Amount:
Per:
<not entered>
Record: 1/1
Warning: Applet Window

EDI FORM


DIUCS v2.1 EDI
Window
ORACLE
EDI_CA1
Emp. Data
Injury
Emp. Signature
Witness
Sup Rpt 1
Sup Rpt 2
Sup Rpt 3
Sup Rpt 4
Safety Data
Sup Signature
Work Environment Exceptions
Employee was member of general pu
Injury resulted from non-work related e
Injury resulted from voluntary participa
Injury resulted from employee eating,
Injury resulted from personal grooming
Injury resulted from a motor vehicle ac
Injury is the common cold or flu.
Check all that apply for the sections on this tab. This information will be used to generate the OSHA 301 notice used for safety notification (Unique to EDI/SAFER) and will not be sent to OWCP.
Privacy Case Status:
A
Not A Privacy Case
General Recording Criteria
Employee is deceased as a result of the incident.
Employee suffered days away from work as a result of the incident.
Employee's work activity was restricted as a result of the incident.
Employee was treated in an emergency room as a result of the incident.
Employee was hospitalized overnight as an in-patient.
Employee lost consciousness as a result of the incident.
Employee was transferred to another job as a result of the incident.
Preliminary OSHA Recordability
29 CFR 1960:
RECORDABLE
OSHA 200 Log Coding:
6
29 CFR 1904:
RECORDABLE
OSHA 300 Log Coding:
J,1
Injury Classification:
A
Injury
As Of:
01-20-2005 02:53:38 PM
Record: 1/1
Warning: Applet Window

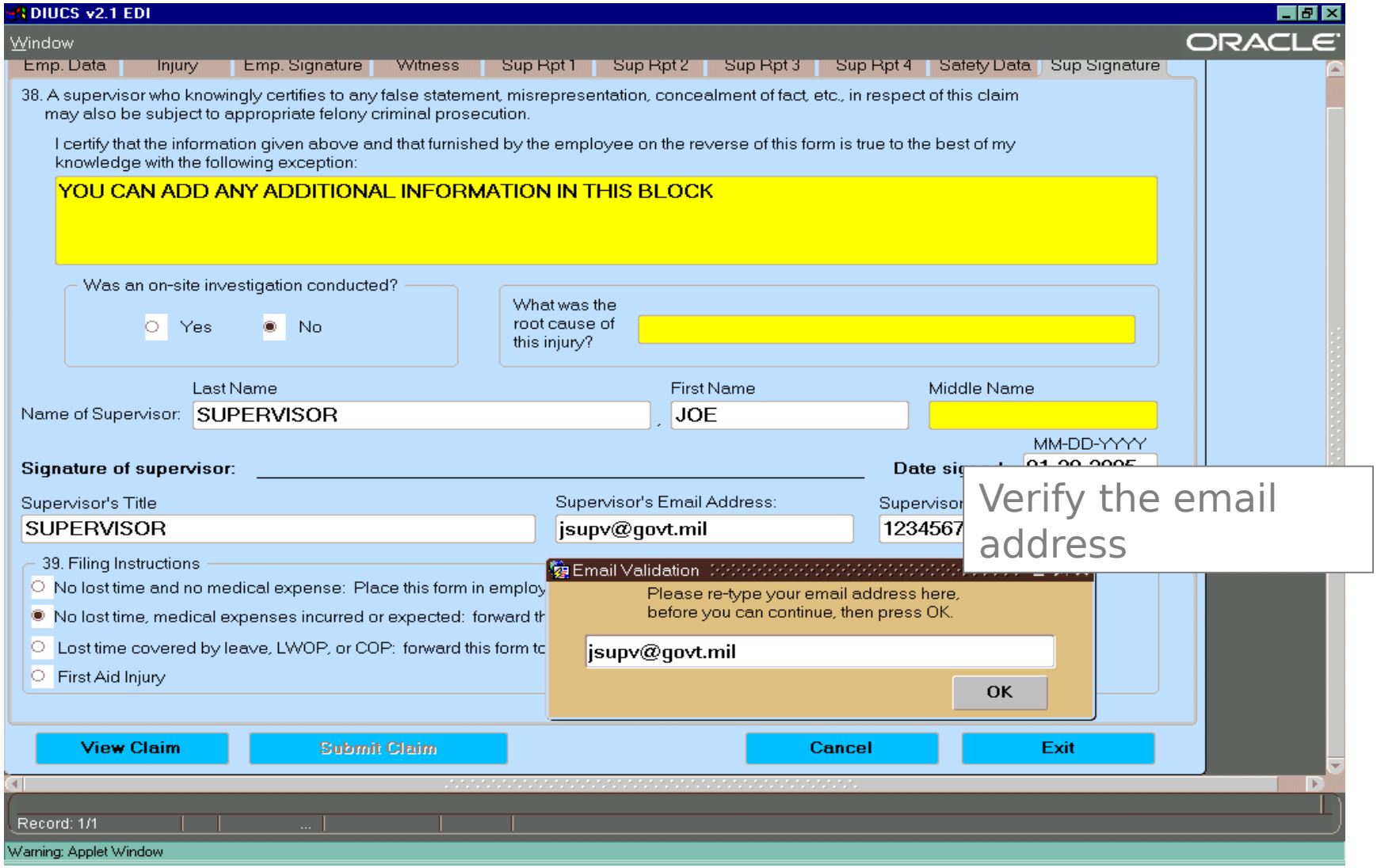
EDI FORM



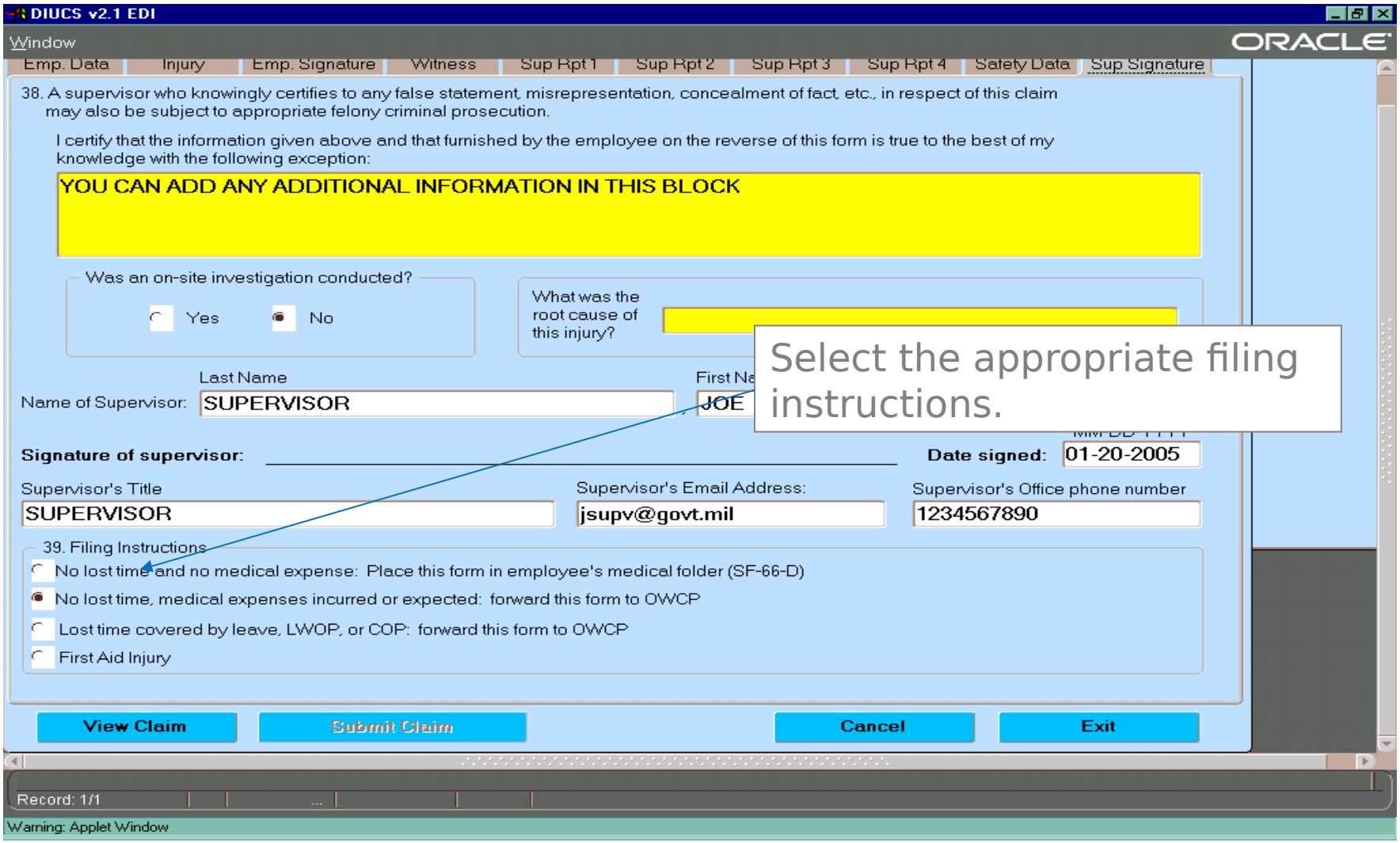
If an on-site investigation was performed then a root cause will have to be entered.

The supervisor's email address should be entered in this field.

EDI FORM


DIUCS v2.1 EDI
Window
ORACLE
Emp. Data
Injury
Emp. Signature
Witness
Sup Rpt 1
Sup Rpt 2
Sup Rpt 3
Sup Rpt 4
Safety Data
Sup Signature
38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.
I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:
YOU CAN ADD ANY ADDITIONAL INFORMATION IN THIS BLOCK
Was an on-site investigation conducted?
Yes
No
What was the root cause of this injury?
Last Name
First Name
Middle Name
Name of Supervisor:
SUPERVISOR
JOE
MM-DD-YYYY
Signature of supervisor:
Supervisor's Title
SUPERVISOR
Supervisor's Email Address:
jsupv@govt.mil
1234567
Verify the email address
39. Filing Instructions
No lost time and no medical expense: Place this form in employ
No lost time, medical expenses incurred or expected: forward th
Lost time covered by leave, LWOP, or COP: forward this form to
First Aid Injury
Email Validation
Please re-type your email address here, before you can continue, then press OK.
jsupv@govt.mil
OK
View Claim
Submit Claim
Cancel
Exit
Record: 1/1
Warning: Applet Window

EDI FORM


DIUCS v2.1 EDI
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ORACLE
Emp. Data
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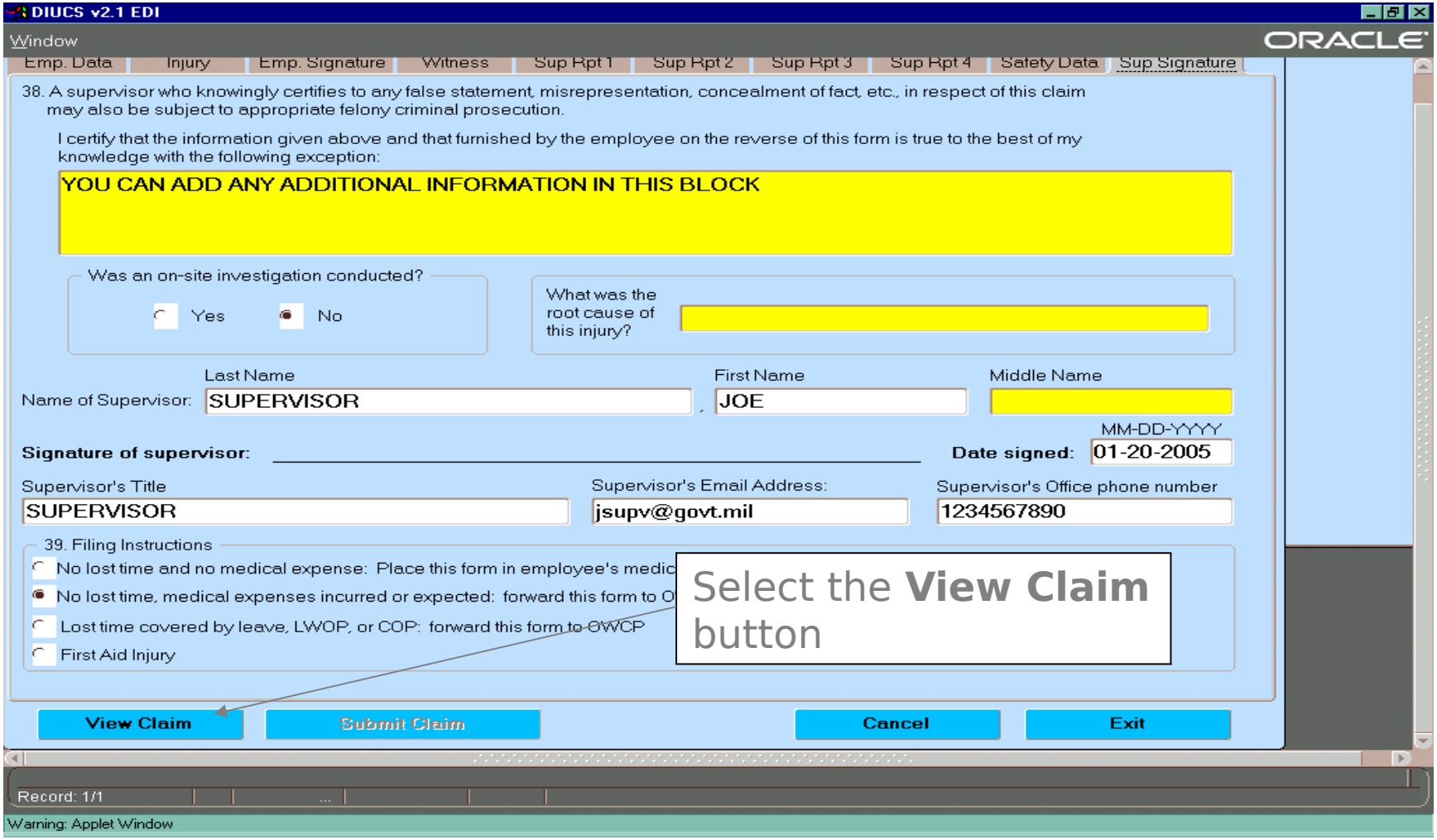
Emp. Signature
Witness
Sup Rpt 1
Sup Rpt 2
Sup Rpt 3
Sup Rpt 4
Safety Data
Sup Signature
38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.
I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:
YOU CAN ADD ANY ADDITIONAL INFORMATION IN THIS BLOCK
Was an on-site investigation conducted?
Yes
No
What was the root cause of this injury?
Last Name
Name of Supervisor:
SUPERVISOR
JOE
Signature of supervisor:
Date signed:
01-20-2005
Supervisor's Title
SUPERVISOR
Supervisor's Email Address:
jsupv@govt.mil
Supervisor's Office phone number
1234567890
39. Filing Instructions
No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)
No lost time, medical expenses incurred or expected: forward this form to OWCP
Lost time covered by leave, LWOP, or COP: forward this form to OWCP
First Aid Injury
View Claim
Submit Claim
Cancel
Exit
Record: 1/1
Warning: Applet Window
Select the appropriate filing instructions.

EDI FORM


DIUCS v2.1 EDI
Window
ORACLE
Emp. Data
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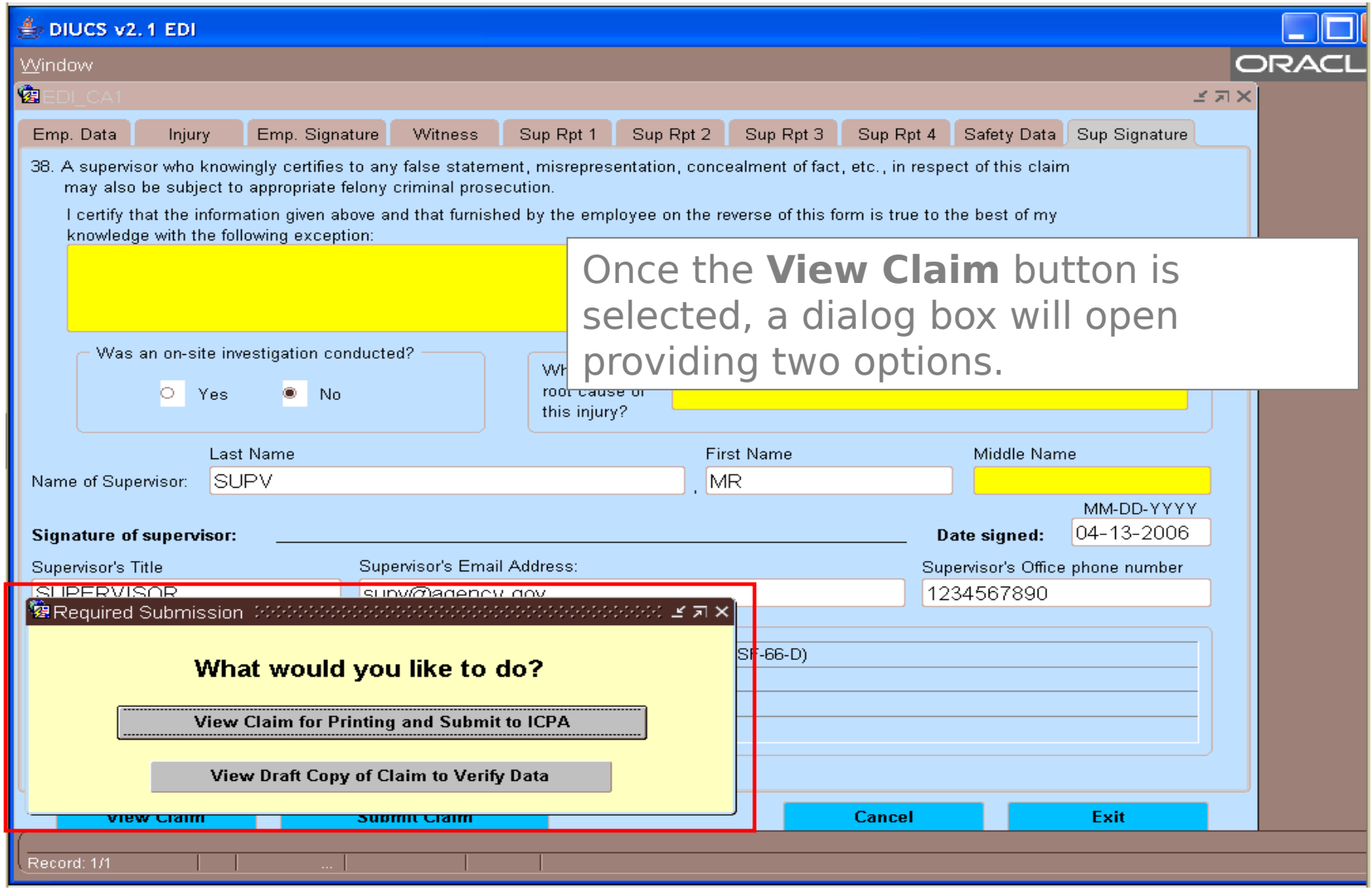
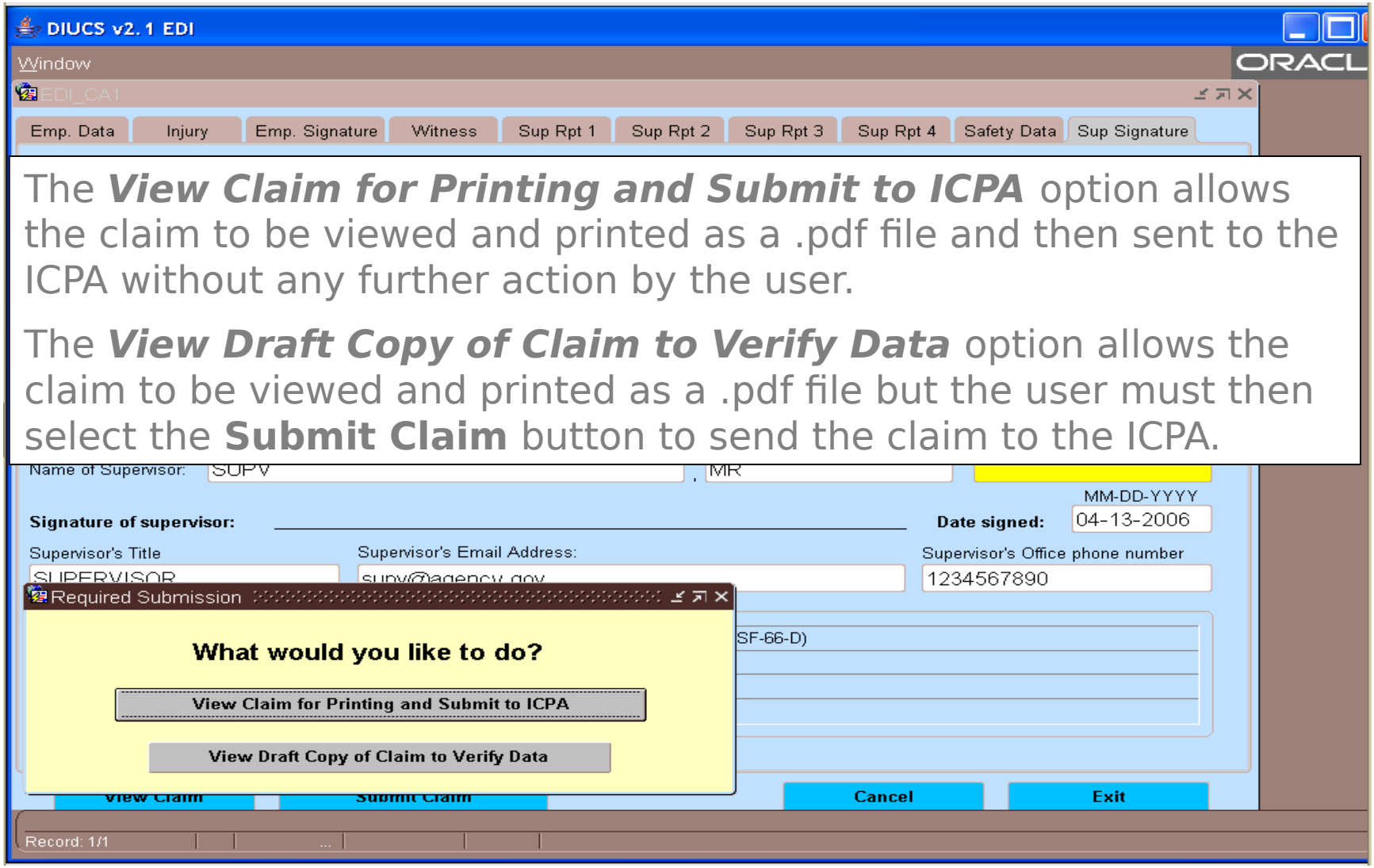
Sup Rpt 1
Sup Rpt 2
Sup Rpt 3
Sup Rpt 4
Safety Data
Sup Signature
38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.
I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:
YOU CAN ADD ANY ADDITIONAL INFORMATION IN THIS BLOCK
Was an on-site investigation conducted?
Yes
No
What was the root cause of this injury?
Last Name
First Name
Middle Name
Name of Supervisor:
SUPERVISOR
JOE
MM-DD-YYYY
Signature of supervisor:
Date signed:
01-20-2005
Supervisor's Title
Supervisor's Email Address:
Supervisor's Office phone number
SUPERVISOR
jsupv@govt.mil
1234567890
39. Filing Instructions
No lost time and no medical expense: Place this form in employee's medic
No lost time, medical expenses incurred or expected: forward this form to O
Lost time covered by leave, LWOP, or COP: forward this form to OWCP
First Aid Injury
Select the View Claim button
View Claim
Submit Claim
Cancel
Exit
Record: 1/1
Warning: Applet Window

EDI FORM

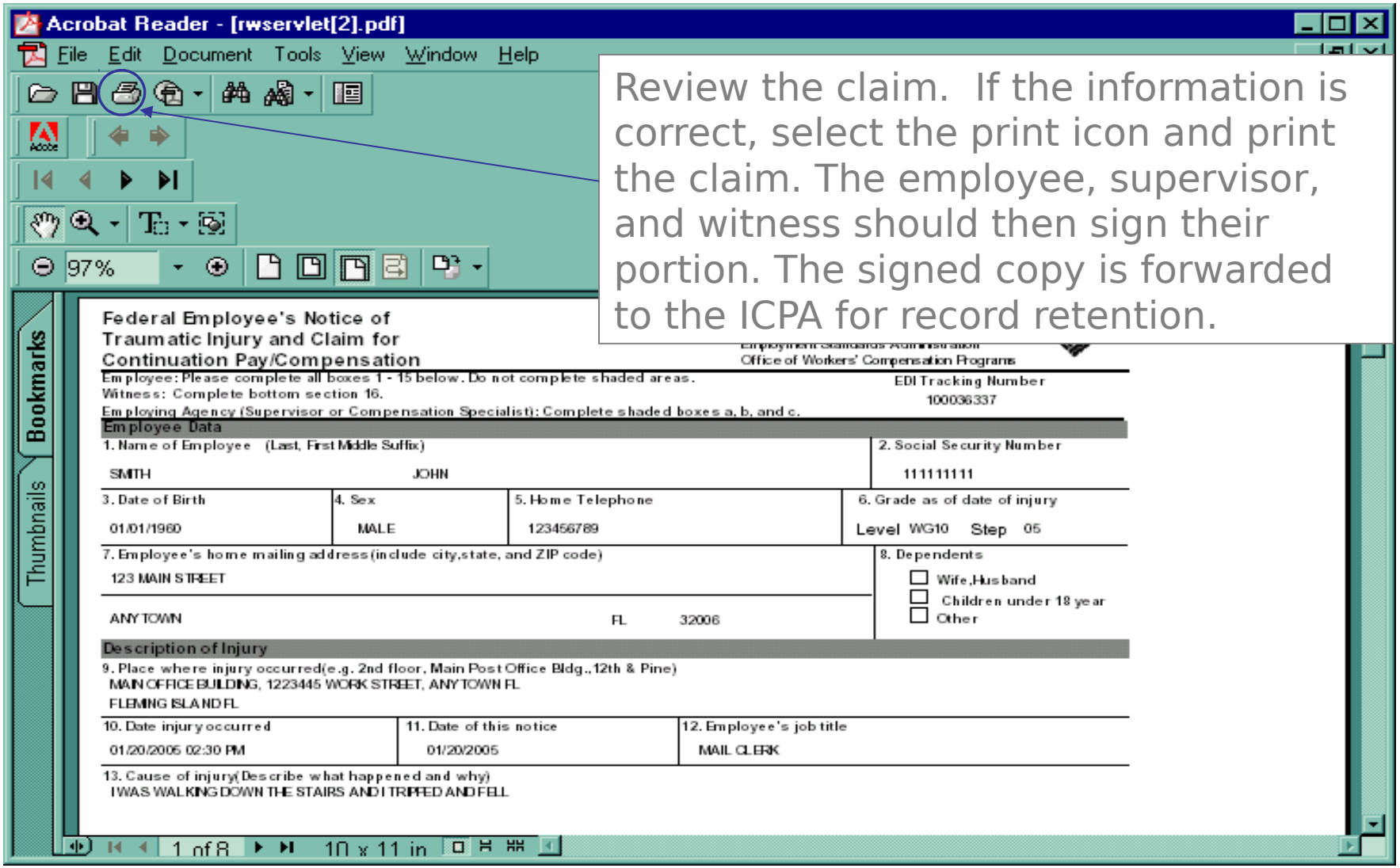


Once the **View Claim** button is selected, a dialog box will open providing two options.

EDI FORM

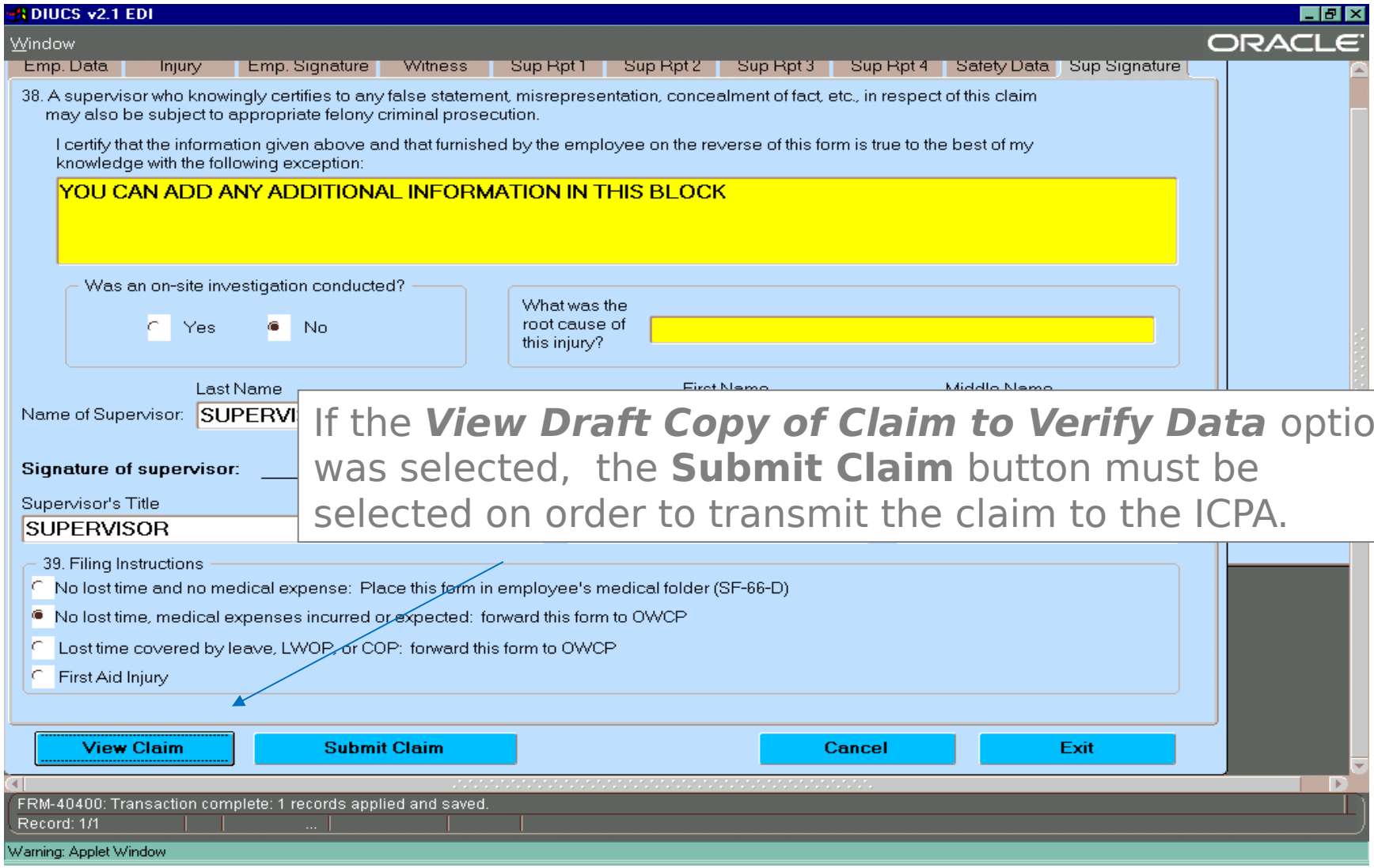

DIUCS v2.1 EDI
Window
EDI_CA1
Emp. Data
Injury
Emp. Signature
Witness
Sup Rpt 1
Sup Rpt 2
Sup Rpt 3
Sup Rpt 4
Safety Data
Sup Signature
The View Claim for Printing and Submit to ICPA option allows the claim to be viewed and printed as a .pdf file and then sent to the ICPA without any further action by the user.
The View Draft Copy of Claim to Verify Data option allows the claim to be viewed and printed as a .pdf file but the user must then select the Submit Claim button to send the claim to the ICPA.
Name of Supervisor:
SUPV
MR
MM-DD-YYYY
Signature of supervisor:
Date signed:
04-13-2006
Supervisor's Title
Supervisor's Email Address:
Supervisor's Office phone number
1234567890
Required Submission
What would you like to do?
View Claim for Printing and Submit to ICPA
View Draft Copy of Claim to Verify Data
SF-66-D)
Cancel
Exit
Record: 1/1

EDI FORM



Review the claim. If the information is correct, select the print icon and print the claim. The employee, supervisor, and witness should then sign their portion. The signed copy is forwarded to the ICPA for record retention.

EDI FORM



If the ***View Draft Copy of Claim to Verify Data*** option was selected, the **Submit Claim** button must be selected on order to transmit the claim to the ICPA.

SUMMARY OF SUPERVISOR ACTIONS

- Supervisor accesses the EDI application through the “Filing Claims Electronically” link on the ICUC Web page.
- Supervisor enters the SSN and Date of Birth of the employee and selects whether a CA-1 or
  CA-2 will be filed
- Employee information is entered onto the form
- Witness information is entered (if applicable)

SUMMARY OF SUPERVISOR ACTIONS

- Supervisor enters required information in Supervisors portion of the form
- The form is printed. The employee, witness and supervisor sign their respective sections.
- “Submit Claim” button is selected and claim is sent electronically to the ICPA.
- Signed claim form is sent to the ICPA to be retained in the file